University of Alberta

ABUSE DURING PREGNANCY: UNDERSTANDING THE SILENCE

by

HEATHER ANN WEIDENHAMER ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF NURSING.

FACULTY OF NURSING

Edmonton, Alberta

Spring 1997

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Degree: MASTER OF NURSING

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **ABUSE DURING PREGNANCY: UNDERSTANDING THE SILENCE** submitted by **HEATHER ANN WEIDENHAMER** in partial fulfillment of the requirements for the degree of **MASTER OF NURSING**.

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Dr. P. Valentine

B. C. Munro

Dr. B. Munro

24 March 1997

Date

DEDICATION

In loving memory of Toby,
my father and spiritual guide.

With love to my mother, Margaret (Emma),
who has been there for me
"through it all".

PREFACE

Fay's Speech to the Mayor

Hello, my name is Fay. I fled an extremely abusive relationship of twenty years with my four children on November 23rd, 1993. I first phoned 911 November 9th during an assault. Two officers came but did not press charges. (Name) states that there is zero tolerance, but that is not being held to. In not only my case, but in many cases. I ended up in hospital, in shock, the next day. None of my bruises showed until 72 hours later. I have found a few individuals on the police force who have been supportive and are able to fully understand the horror women and children in our situation live. Many officers have laughed off (the abuse) or made snide remarks, not shown up when called for standby, been witness to, but not documented, threats, verbal, emotional, and psychological abuse women and children suffer in their presence. Why won't the police document these things? It would help us to have their credible witness. Instead, we are asked to let it go, further victimizing the victims. In court cases, the men are acquitted for consensus assault because we won't leave our children and we can't get past our abuser. Judges listening to so many cases see often only a lover's quarrel, and in fact we are fighting for our lives and our futures, for ourselves and our children. Children are witness to the power imbalance and the rage in them, because of their powerlessness to help us or themselves, is a root of most youth crime, suicide, and runaways. When they see their abusive parent, in our case, their father, get away with assaulting, lying, threatening, et cetera, they learn to follow that model. Judges who don't grasp the issue of family violence and its consequences are perpetuating the cycle by their apathy or denial. I've been the target of condemnation, patronization, condescension, blame for leaving, and blame for staying. I want and will fight for a better life for my children. I will not use the terms legal or justice systems as they are illegal and unjust. The children always suffer the most. We live in poverty at the mercy of a merciless injustice system and the batterers who live a high life. I'm angry at the snail's pace that only brings more and longer lasting effects from the battering. The last of which, is the enormous financial toll of court costs et cetera. Mine is over twenty thousand dollars now to date. Changes are too slow in coming. A whole new army of children are soon to be flooding the schools. Stop the batterers and not the victims. There's a desperate need for at least one family violence team on the south side. I have the benefit of (name) and (name). (Name) was a social worker and had advocated for me at mediation when I was terrified to go in alone, in case my husband had gotten me in the parkade. If it hadn't been for a generous gift from the (name) family at Christmas, I wouldn't have been able to afford a phone. It would cost me five hundred dollars. A necessity in our situation for safety because many of us have children and no cars or sitters. A telephone enables us to accomplish much needed steps in our battle. However, I know of many women who have not this life line because of EdTel's deposit policy of five hundred dollars. I ask that there be made a special consideration for battered women coming out of shelters or their homes, to provide phone services without this deposit. The obstacles sometimes seem so overwhelming that without community help and individual counseling, we often return to the batterer. This time I was blessed to hear about Family and Community Services. With their support and the Family Violence Team, we have come slowly but surely. The children and I hope a little more. We will not be victims anymore. Every community police station must be well stocked in pamphlets and reading material on family violence. It's a malignant cancer in our community. We must get education out of every possible public service facility, and in different languages. I may sound angry, it's because I am. I entered a shelter a walking corpse with my terrified children. I've overheard my eight year old son say in a quiet, gentle voice, "I saved my mommy's life. I thought my dad was going to beat her inside out with the phone". And to the police he said, "Please take us out of here. My dad is whacko". We each have woken up screaming, "No!" Our unconscious remembering of the fear and violence we lived; post traumatic stress syndrome. The children still receive counseling, as do I. This is an emotional issue. I feel angry that changes are slow in coming, that our cries often fall on deaf ears. Ears that want to deny the horror because it makes them uncomfortable. I feel angry at the injustice system, for their failure to protect us. We are treated as the criminal. We are held accountable and the batterers are let off. Judges, I appeal to you, do not interim custody on ex parte until you have psychiatric assessment of the woman. Many husbands use that maneuver as their threat. Children become hostages and bait. The batterers are true Jekkyl and Hyde individuals. I find it an irony that my husband's father escaped a prison term in Germany for assaulting a man. He lives in Canada and has not been brought to justice. It's a common experience for us to be abandoned by our churches and families. We depend on Community and Family Services, judges, and police working together to break the cycle of violence.

To My Daughter Emily

Precious baby Emily. Today is Thanksgiving. A day to give thanks and if there's anything I can be thankful for this year it would be that God had given me you, if only for a short time. You did not cry, you did not breathe, but you gave me more than I can ever imagine. I won't have memories of you at one or at five or even at twenty, but I will cherish the memories of carrying you. I carried you, you carried me. We could not go alone. You were a beautiful gift from God. He gave you to me for a reason. I give thanks today. So many dreams, hopes, a new beginning. You've given me strength to carry on, courage. I only wanted the best for you but I see now God had a plan and that he needs you more right now. I love you Emily, with every fiber of my body. I'll miss those times when you kicked or got excited when the choir sang in church. You lived for me all that time, in the dark chamber of my womb. You knew everything that was going on. I tried to keep you safe, protect you. You felt my sadness, my pain. You knew I was tired and hurting, but you gave yourself so that I may have a new beginning, a new life. It was in the spring when you left. Springtime, a new beginning, flowers in bloom, new forms of life, rebirth. A time for repotting, a time to plant seeds. I'll always be reminded of you every spring. A time to repot more roots that can reach into greater faith and trust in myself and my ability to survive. You've given me strength and wisdom to repot myself in a way that allows me to heal, when anchoring my roots in new circumstances. I turn my face to the sun, my baby Emily. You've given me so many beautiful gifts I so greatly receive with all my heart. You've given me freedom from abuse. I'll cherish that forever. You are a precious angel. My little angel. Some people only dream of angels. I held one in my arms. I shall carry you with me forever my child, you are always mine. You are mine now. Today is a special day, Emily. I see things more clearly. I understand. I give thanks. I've had to face life right on. I've had to accept things, feel things, forget things, leave things - to change things. I couldn't of done any of these things had not God given me an angel, so precious, so beautiful in your tiny body. So perfect. The years of sadness, hurt, abuse - it's over Emily. I don't need to suffer anymore and neither do you. Peace be with you always baby Emily. For such a short life you've given a lot of life to others. I am eternally grateful and one day we'll be together again.

> Dear God, look after precious Emily. Hold her in your arms, keep her warm and safe, protect her. Keep her well for she has kept me safe and protected me and surrounded me by others who share and care.

ABSTRACT

The purpose of this exploratory descriptive study was to explore the emic perspective of women who were abused during pregnancy. Seven informants (abused during pregnancy within 5 years of the time of the interviews) were recruited by an advertisement in a community newspaper, at women's shelters, and a follow-up support group for abused women. Ethnographic methods were used to analyze the data obtained from the face to face, open-ended interviews. All of the women had left the relationship and one woman was pregnant at the time of the interview. Although women told their stories of abuse during pregnancy within the broader context of their abusive relationships, the relationship between abuse and pregnancy was described. Each woman's experience was unique, however common themes were identified.

Implications for education and practice were gleaned from the women's stories. Further education is required for victims of abuse, helping professionals, and the general public. All pregnant women should be screened for abuse in a direct but sensitive, non judgmental manner in a private setting. It is essential that disclosures of abuse are believed, resource information is provided, and the women are respected and supported in their decisions.

ACKNOWLEDGMENTS

I would like to express my deep respect and gratitude to the women who participated in this study. I admire the strength and courage they possess and thank them for sharing their painful memories with me. It was truly a privilege to hear their stories. They have touched my life in a personal and professional manner. I hope their words will have an impact on the lives of others.

Dr. Peggy Anne Field, my thesis supervisor, is a woman whom I hold in high esteem. Thank you for your guidance, dedication, understanding, and support from beginning to end. I would also like to extend my sincere thanks to my committee members, Dr. Patricia Valentine and Dr. Brenda Munro for sharing their expertise.

I wish to acknowledge Shirley Yakimishyn and Tessa Merry, from the Victorian Order of Nurses, for sharing their wisdom with me during my time spent at the women's shelters and for their interest in and support of my study.

A special thank you to Margaret Scherger for your transcribing and formatting skills.

To my family and friends, too numerous to name but they know who they are, I extend a heart felt thank-you. The love and support they provided will never be forgotten.

Finally, I would like to acknowledge the Alberta Association of Registered Nurses for the financial support they provided for this research study.

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CHAPTER I

INTRODUCTION

Statement of the Problem

The violence which occurs against women is a major social and health concern. It is quite possible that abuse has been present since the beginning of time, yet this issue has only recently received attention in our society. Attitudes toward women and the treatment of women have been affected by many historical and social factors. Physical and mental cruelty have only been grounds for divorce in Canada since 1968 (Bain et al., 1991). In recent years there has been a movement to equalize the status of women to the status of men. Societal awareness of the extent of violence against women has increased since the initial reports were published in the 1970's (McLeer & Anwar, 1989). Since then, the nursing profession has contributed to a multi-disciplinary approach which has resulted in the expansion of resources directed toward protecting the victims of violence and reducing the incidence of violence. Numerous studies have been conducted which contribute to our knowledge about violence against women, however, many aspects remain unexplored. It is difficult to imagine a man intentionally injuring his partner when she is pregnant with their child, but it happens. The experience of the woman who is battered during pregnancy is only beginning to be explored from the woman's perspective. The battering which occurs during pregnancy places both the woman and her child at risk for negative health consequences. In order to provide appropriate and sensitive care, the stories of these women must be heard by health care professionals.

Purpose of the Study and Research Question

A review of the literature has shown that the phenomenon of battering during pregnancy is a health and social concern of significant proportion in Canada. However, previous studies have only focused on estimating the prevalence and identifying the consequences. Despite the numerous research studies which have been conducted to study battering during pregnancy, a gap in the literature exists related to understanding the experience from the woman's perspective. It is not appropriate for health professionals to focus solely on the measurable outcomes of abuse. It is necessary to seek an understanding of the effect that battering during pregnancy has on the woman. Exploring the issue from the woman's perspective provides direction for health service planning and policy formation (Leininger, 1969). This study contributes to the identification of concepts as a means to understanding human behavior. These cultural concepts provide the basis for the continuing generation of hypotheses and theory (Aamodt, 1982). Health care professionals can learn from the experiences of the patients we care for, this information is critical to the provision of sensitive, appropriate care. The purpose of this research was to explore in context, describe, identify, and provide theoretical analysis of the experiences of women who have been battered during pregnancy.

There is a need for health care professionals to be more knowledgeable and sensitive to the problem of battering during pregnancy. The research question which guided this study was: "What are the experiences and perceptions of women who were abused during pregnancy?"

Significance of the Study

The women who have been battered during pregnancy are the experts on this phenomenon. Listening to their stories can provide valuable insight into the complex issues they face. Information on the women's values, beliefs, coping mechanisms, and decision making can be gleaned from their stories. An understanding of the women's needs and struggles can assist helping professionals to provide the appropriate, sensitive care to which these victims are entitled. It is only with this awareness that attitudes and judgments can be changed, and the women will receive the respect they deserve. It is essential that professionals become involved in situations of domestic violence, but equally essential is the approach utilized. Counter productive interventions can occur when helping professionals lack knowledge or understanding of battering in pregnancy. The women's experiences will serve as a guide to the approach, assessment, and intervention strategies that will effectively assist women in making healthy life decisions and will lead to an improved state of being for themselves and their children.

The following chapter contains a review of the literature relevant to the research question and provides additional rationale for the study. Chapter III entails a description of the research method used and includes information on the sample, data collection and analysis, rigor and validity, and ethical considerations. The findings are presented in Chapter IV and includes extensive quotes from the informants. Conclusions and implications of the findings for practice, research, and education are presented in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

A literature review to examine previous research was conducted. The literature review served to guide the researcher in selection of the appropriate method of inquiry for studying the research question. Data bases searched include references from MEDLINE, PSYCHLIT, and CINAHL. Content, underlying assumptions, biases, and context of each study of the relevant literature was reviewed. By this method, the researcher was informed but the current analysis was not limited (Field & Morse, 1985). Following data analysis, additional recent literature was reviewed and incorporated.

Prevalence

Abuse is a characteristic which exists across all ethnic, religious, socio-economic, education, and occupation boundaries (Lent, 1991; Moss & Taylor, 1991; Walker, 1984). Battering of women is an under reported crime that has serious health consequences (Campbell & Humphreys, 1984). It has been estimated to be under reported by as much as 40% (Shipley & Sylvester, 1982). A national Canadian survey found 25% of all women have experienced violence at the hands of a current or past marital partner (including common-law unions); the estimated percentage of women over 18 years of age who have experienced physical or sexual assault since the age of 16 in Alberta was reported to be 58% (The violence against women survey, 1993). The incidence of wife assault in Edmonton involving physical aggression was reported to be 14.1% by Kennedy and Dutton (1987), and 10.7% by Ratner (1991). Ratner (1991) found that 32.4% of the women surveyed in Edmonton were psychologically abused.

The issue of violence against women during pregnancy has only recently received attention as the incidence is becoming more widely known. Study results of estimated prevalence vary due to differences in the definitions of abuse, time frame of the violent events, populations, data collection methods, number of times participants were queried, and specifications of the perpetrator. Although it is difficult to assess the actual incidence, studies have indicated that abuse occurs during 7% to 17% of all pregnancies (Amaro, Fried, Cobral, & Zuckerman, 1990; Campbell, Poland, & Waller, 1989 as cited in Bohn & Parker, 1993; Helton, 1985, 1987; Helton, McFarlane, & Anderson, 1987a; Helton & Snodgrass, 1987; McFarlane, Parker, & Soeken, 1996; McFarlane, Parker, Soeken, & Bullock, 1992). A study conducted by Helton, McFarlane, & Anderson (1987b), which had a broad definition of abuse, found 36% of 290 pregnant women were battered or at risk for battering. It has been estimated that one in every ten women in Canada will be the victim of violence during pregnancy (Kennedy & Dutton, 1989). The Statistics Canada survey found violence during pregnancy was experienced by 11% of women with their current partner and

26% with a previous partner (The violence against women survey, 1993). Findings from studies show that approximately half of all battered women are abused during pregnancy (Bowker, 1983; Brendtro & Bowker, 1989; Campbell, 1986; Fagan, Stewart, & Hanson, 1983; Flynn, 1977; Stacey & Shupe, 1983; Stewart & Campbell, 1989; Walker, 1984). Prior abuse was found to be a primary predictor of abuse during pregnancy for 87.5% of the women who participated in a study conducted by Helton et al. (1987a).

Pregnant women's risk of violence was found to be greater than that of non pregnant women (Helton, 1986; Walker, 1984). In a study conducted by Gelles (1988) men reported that they were more violent toward their pregnant partners than men whose partners were not pregnant at the time of the interviewing. The first episode of violence may be precipitated in some relationships by the pregnancy (Gayford, 1978; Hillard, 1985). The violent episodes began during pregnancy in 47% of the women surveyed in Canada (The violence against women survey, 1993). Helton et al. (1987a) found more commonly the violence occurred prior to the pregnancy. A history of abuse was reported by 11% to 23% of pregnant women and reports indicate that their risk of abuse during pregnancy increased (Campbell & Alford, 1989; Helton et al., 1987a; Hillard, 1985). Abuse increased following knowledge of pregnancy in 29% of the 290 women studied by Helton et al. (1987a). A study conducted by Stewart & Cecutti (1993) found that 64% of the women reported an increase of abuse during pregnancy and 14%

indicated the first abusive episode occurred during pregnancy. Although 67% of the women had received medical treatment for abuse, only 3% disclosed to their prenatal care providers.

Controversy has existed about whether the association between pregnancy and violence is actually an artifact of age because young women have higher rates of pregnancy and experience violence at a relatively higher rate (Gelles, 1988). Regardless of which variable violence is associated with, society must provide appropriate intervention and preventative services for this population.

Health Consequences

Battering during pregnancy affects the health of both the pregnant woman and the unborn child. Dislocated joints, burns, contusions, concussions, lacerations, fractures, internal injuries, and gun shot wounds are reported as common physical injuries experienced by abused women (Helton et al., 1987b; Stacey & Shupe, 1983). Studies have indicated that battered women are more likely to have complications of pregnancy such as miscarriage, preterm delivery, low birth weight infants, fetal injury, and fetal death following a battering episode (Amaro et al., 1990; Bullock & McFarlane, 1989; Campbell, 1989; Stark et al., 1981). A study of 205 pregnant women found 8.8% experienced pregnancy complications consisting of preterm labor, placental separation, fetal injury, and fetal death (Goodwin & Breen, 1990). The number of physically abused women in

Edmonton who reported having one spontaneous abortion was 16.3% compared to 11.8% of women who were not abused (Ratner, 1991). Battered women are more likely to have a history of one or more elective abortions than non battered women (Amaro et al., 1990; Evins & Chescheir, 1996; Stark et al., 1981). The abuse related abortions and miscarriages are also associated with health risks for the woman, such as infection, excessive blood loss, cervical and uterine trauma, and disseminated intravascular coagulation (Hatcher et al., 1986; Whitley, 1985). Women who were abused during pregnancy were found to be more than twice as likely as non abused women to have a history of sexually transmitted disease (Amaro et al., 1990). Women who are battered during pregnancy often do not receive adequate prenatal care (Campbell et al., 1989 as cited in Bohn & Parker, 1993; McFarlane et al., 1992). Abused women were found to be twice as likely to begin prenatal care in the third trimester when compared with non abused women (McFarlane et al., 1996).

Clinical and descriptive research results have suggested that the nature of the violent attack changes when the woman is pregnant with the abdominal area being the focus of assault (Helton, 1986; Hilberman & Munson, 1978; Stark, Flitcraft, & Frazier, 1979). As well, women abused during pregnancy have reported trauma to the breasts and genitals, and sexual assault (Walker, 1979). Abused pregnant women were more likely to have multiple trauma sites than abused non pregnant women (Helton &

Snodgrass, 1987). Physical abuse has been shown to frequently escalate to homicide (Browne, 1989). Trauma is the leading cause of maternal death during pregnancy, followed by suicide (Baker, 1982; Bremer & Cassata, 1986). According to the Statistical Synopsis of homicide in Canada (as cited in Lent, 1991) 97 women were killed in domestic disputes in 1988.

The reported psychological health consequences of abuse include substance abuse, (Amaro et al., 1990; Bullock & McFarlane, 1989; Hillard 1985) suicide attempts, and depression (Amaro et al., 1990; Gayford, 1978; Hilberman & Munson, 1978; Hillard, 1985; Stark et al., 1981). Of 742 prenatal clients, 20% had attempted suicide (Hillard, 1985). Significant correlates of battering during pregnancy were found to include anxiety, depression, housing problems, inadequate prenatal care, drug and alcohol use, and less assistance from family members (Campbell, Poland, Waller, & Ager, 1992). Walker (1984) reported battered women were more likely to use alcohol, illicit drugs, and prescription drugs as means to cope with the violence.

The literature related to battering during pregnancy has mainly focused on the prevalence, associated factors, and the physical and emotional outcomes of the abuse on the victim. Theories related to the cycle of violence have been developed (Hutchinson, 1988, as cited in Parish et al., 1996; Yakimishyn, 1991). While these issues relate to the topic, they were not the focus of this study. In spite of the high incidence rates, no research has been identified that seeks to develop an understanding of the experience of battering during pregnancy from the woman's perspective. Many health care professionals fail to intervene in cases of suspected abuse, despite the existence of guidelines to assist them with intervention (Campbell, Pliska, Taylor, & Sheridan, 1994; Meskin, 1994; Walker, Jones, & Krohmer, 1991; Williams, 1995). An understanding of the complexities of abusive relationships and greater empathy for the victims can be gained by hearing the women's perspectives of their experiences. It is only with this awareness that attitudes toward and the approach with battered women will change. The vulnerability of the pregnant woman and her unborn child is sufficient to warrant the need for further research in this area from an emic perspective.

CHAPTER III

METHOD

The purpose in this research study was to gain a better understanding of women's experiences of being abused during pregnancy. A qualitative, exploratory descriptive design, using ethnographic methods, was selected as the framework that suited the research question and population of this study.

Qualitative methods were selected because little was known about women's own experience of being abused while pregnant. In this study, the informants were considered a cultural group based on the common aspect of their life of having been abused during pregnancy. The goal was to identify the health beliefs, values, and practices of women who are abused during pregnancy through an analysis of the detailed descriptions of their experiences. From this information, implications for helping professionals were formulated.

A definition of terms, description of the sample, methods of data collection, and data analysis that were used in this study are presented below. Ethical considerations, and the study's rigor and validity are also discussed.

Definition of Terms

In order to sensitize the researcher to the potential range of abuse that could occur, the following definitions were developed:

'**Abused woman**' is a woman who has experienced physical, psychological, or sexual abuse by an intimate partner, endangering her survival or security. This definition has been adapted from the definitions used by Innes, Ratner, Finlayson, Bray, & Giovannetti (1991); Ratner (1991); Saunders (1986); Turnbull Buehler (1994); and Walker (1979). This includes any adult female in an abusive intimate relationship regardless of legal marital status or gender of the intimate partner.

'**Psychological abuse**' is the use of verbal and nonverbal acts which symbolically hurt another, or the use of threats to hurt another or oneself (Strauss, 1979).

'**Physical abuse**' is the use of violence in the form of bodily aggression; an act which threatens or causes physical injury to another person (Brinkerhoff & Lupri, 1988).

'**Intimate partner**' is the man or woman who lives or lived in an intimate relationship with, and abused the woman during pregnancy, regardless of the legal marital status. Although women are abused by people other than their intimate partner, this study focused on abuse which was administered by the woman's intimate partner.

'**Pregnancy**' entailed the period of time from conception to termination of the pregnancy, regardless of the outcome (e.g. spontaneous abortion, elective abortion, stillbirth, or preterm delivery).

The Sample

Appropriateness

It has been claimed that the best judge of whether or not abuse has occurred is the woman herself (Walker, 1979). Therefore, the sample for this study consisted of informants who were selected from a volunteer population of women, in Edmonton, who defined themselves as being abused during pregnancy. The definition of abuse would have been used as a secondary screen should a woman volunteer who did not appear to be speaking of abuse.

The population from which informants were selected included women who were:

1. English speaking.
2. 18 years of age or older. Younger adolescents were exluded as earlier work has suggested that the experience of this group is different from the experience of adult women who are abused (Parker, 1993).
3. willing to participate.
4. interested in the study as opposed to expressing a need for therapeutic assistance.

5. self defined as having been abused during a current pregnancy or abused during a pregnancy within the past five years by an intimate partner. Informants in previous studies were found to be able to provide clear descriptions of experiences which occurred five years previous to the interview (MacNeil, 1993; Morgan, 1987). The five year time frame placed the experience of the women in a historical context and served to decrease the potential threat of retrospective bias. As well, the concerns about the availability of informants is eased somewhat by the allowance of the five year time frame (Sandelowski, 1986).
6. able to clearly express their thoughts, feelings, and perceptions. Informants who were able to reflect and provide information about the topic were essential to the quality of the research.

The legal status of the relationship between the woman and her partner was not specified as inclusion criteria based on the findings of Ratner (1991) that 7.9% of physically abused women in Edmonton were in marriage relationships and 9.6% were in common-law relationships.

The gender of the perpetrator was not specified as it was the women's experience of being abused during pregnancy which was of primary interest to the researcher, regardless of whom the intimate partner might have been. The criteria allowed for variation in the sample which increased the representativeness of the data.

Access Procedures

Purposeful selection was the primary method of sampling, however potential informants were to a degree self selected by their voluntary response to advertisements. An advertisement (Appendix A) with the research study telephone number and a brief description of the purpose of the study, was placed in an Edmonton community newspaper three times to solicit informants. The 'Advertisement for Informants' (Appendix A) was posted at the Women In Need Growing Stronger (WINGS) secondary housing agency. The researcher attended one group session at WINGS to present information about the study. Follow-up workers provided information about the study at two of the Beverly Community Center follow-up groups for abused women. The 'Information for Potential Research Participants' forms (Appendix C) were distributed to interested potential participants at both agencies. Ethical clearance was obtained from the Royal Alexandra Hospital, however it was not necessary to post advertisements in this location as no further informants were required.

The women who were interested in participating in the study contacted the researcher by telephone for further information regarding the study. Respondents were assessed by the researcher according to the 'Criteria for Selection of Informants' (Appendix B) for suitability as research participants. Women who qualified were provided with additional information by the researcher about the study, inclusion criteria, and time commitments related to their participation. Sixteen potential informants contacted the researcher through these means, seven of them were selected as primary informants. Most women who contacted the researcher were responding to the advertisement in the community newspaper. Of the primary informants, three were acquired via the newspaper advertisement, two were acquired via the Beverly Community Center follow-up group, and two were acquired from the WINGS secondary housing agency.

The researcher reviewed the information from the 'Information for Potential Research Participants' (Appendix C) and asked each potential informant if she was willing to participate in the study. If the woman verbally consented to participate in the study, a meeting time and place which was considered convenient and safe for both the informant and the researcher was established. The written 'Informed Consent Form' was explained and signed, with a copy being provided for the informant at the time of the first interview (Appendix D). If a woman had preferred telephone interviews it would have been arranged. All interviews in this study were conducted face to face. Field notes were made immediately following the interview.

Adequacy

A sample size of eight to ten informants was stated to be sufficient for the purpose of this type of qualitative study for identifying common themes and patterns (Leininger, 1984). In total, seven primary informants were interviewed for this study, with informants being recruited until no new information was obtained. The exact sample size was not predetermined because the sampling was dependent upon the nature of the data as opposed to the number of informants (Sandelowski, 1986). Adequacy of the sample size for qualitative research is determined by saturation of data, that is, when no new data emerges from informants' interviews (Morse, 1992). As categories and themes emerged, purposive sampling was performed in order to select informants who could validate, clarify and test the themes, and provide additional information. Of the seven primary informants, one had experienced psychological abuse during a previous pregnancy, one had experienced physical and psychological abuse during a current pregnancy, and five had experienced forms of physical and psychological abuse during a previous pregnancy. The sample of seven primary informants provided sufficient data for common themes to be identified during analysis.

Two volunteers, who met the criterion of having been abused during pregnancy, were used as secondary informants. These volunteers were individuals who contacted the researcher but had not been interviewed for the main study. They were utilized to validate emerging themes. An informed consent (Appendix H) was obtained and arrangements were made for an interview in a similar manner to that used with the primary informants. They did not provide any additional information, but they did validate that the findings 'fit' with their experience of being abused during pregnancy. In addition, the researcher's clinical practice on a tertiary care labor and delivery unit provided interactions with women who were abused during pregnancy. These interactions served to further validated the findings of this study.

Data Collection

The method of data collection was in-depth, open ended interviews. Open ended interviews were used because little was known about the women's perspective of their experience and therefore, no knowledge base existed upon which to structure the interview. Information regarding beliefs, feelings, and perceptions was obtained through the use of these interviews. Considerably higher rates of abuse, abuse during pregnancy, sexual abuse, and fear of the male partner have been recorded during nurse interviews as opposed to self-reports (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991). Differences in researcher perceptions and participants' meaning were clarified during the second interview. Interviews progressed from a general to a more specific information seeking format with new questions being based on information provided in the first interview.

Prior to conducting the interviews, feedback from experts in the area of abused women was sought regarding the appropriateness of the prompt questions and the approach of the researcher. All informants were interviewed once in person. A second interview was conducted with six of the seven primary informants in order to clarify details from the transcribed data. The seventh participant was admitted to hospital and was not available for a second interview. The opening interview question was quite general in order to allow the informant to describe personally relevant experiences from her unique perspective and without influence from the interviewer. Informants were encouraged to tell stories and this proved to be an effective way of capturing the personal and cultural meaning of an experience. Each session lasted approximately one to two hours, depending on the flow of the woman's story, and was prompted as necessary by the researcher asking open ended questions (Appendix E). The interviews were scheduled approximately four weeks apart to allow for transcribing and analysis of the interview as this provided direction for subsequent interviews. Guiding questions were incorporated at different times during the study which addressed topic areas described by previously interviewed informants. Biographical data were collected on each informant at the end of the initial interview using a form developed by the researcher (Appendix F).

The location and time for the interviews were mutually agreed upon with consideration of convenience and safety for both the informant and the researcher. The interviews were audio-taped and transcribed verbatim. Verification of themes occurred throughout the interview process by primary informants.

Field Notes and Setting

The researcher completed field notes as soon as possible after each interview. The field notes were categorized and coded to facilitate retrieval. The notes were used to supplement the audio-tape and contained recordings of nonverbal behaviors, physical environment, and other factors that may have influenced the interview in order to add to the richness of the data. All interviews, except one, took place in the informants' homes at a mutually convenient time. One interview took place at the educational institution the informant was attending. Most interviews took place in the living room or the kitchen, usually over a cup of tea or coffee. All of the settings were comfortable with only occasional interruptions such as pets, children, or telephone calls. Some informants seemed slightly anxious initially about being audio-taped but they seemed to forget quickly that they were being recorded. All informants seemed comfortable with the researcher. Informants' nonverbal behaviors were congruent with verbal behaviors. For example, if they verbalized distress, they cried or looked distressed by their facial expressions.

A personal journal was kept by the researcher for the purpose of recording thoughts and feelings during the study. This process of reflection increased the researcher's level of self-awareness and lessened the threat of researcher personal bias and assumptions.

A decision journal was kept for the purpose of recording the theoretical and analytical processes and decisions made throughout the entire research process, such as memos containing the researcher's interpretation of the data. A record of how and why decisions were made formulated an audit trail which contributed to the rigor of the investigation.

Data Analysis

Analytic processes of ethnography focus on generating categories and discovering relationships between these categories. Data analysis occurred simultaneously with sampling and data collection. Data from all sources, such as transcripts, field notes, journals, and biographical data forms were analyzed to create a total picture. The transcripts and field notes were read numerous times in order to become familiar with the data. The goal of the analysis was to provide a thick description of women's perceptions of their experiences of being abused during pregnancy.

The method described by Spradley (1979) was used as a guide to code and organize the data. Each informant's transcript was coded by color and letter which identified the source of the data. Key words, salient words, and repeated words were identified in the data, for example "behind closed doors" was a key phrase. Domains, or categories, were formulated from these coded segments by examining the semantic relationships. For example, informants were asked to explain the meaning of "behind closed doors" and to provide examples of the perpetrators' behavior that supported this phenomenon. From these descriptions, common characteristics of the perpetrators were identified, such as, manipulative and having a public and private personna. The codes changed as the categories were elaborated or collapsed. For example, the informants further explained how they, as victims, would try to keep the abuse hidden from others. The women explained how they kept the abuse hidden by denying, minimizing, and providing alternate explanations for injuries. From the examples they provided, common characteristics of the informants were identified, such as, self-blame and low self esteem. Domain analysis continued as new data were collected from interviews. A category emerged encompassing reasons for remaining silent and further exploration revealed fear as a major contributing factor to the victims' silence. Common themes, which explained how the domains were connected in the lives of the informants, assisted in making the implicit meaning explicit. For example, commonly held fears such as fear of violent retaliation, fear of losing custody of their children, and fear of financial instability were then idenitified. The womens' fears were supported by the numerous examples of threats and abusive measures employed by their partners as a means to gain or maintain power and control over them.

Notations were made about ideas for follow-up throughout the data analysis process. Preliminary explanations guided the search for patterns and additional data collection (Cobb & Hagermaster, 1987). For example, information on the experience of disclosing was sought and included discussion of factors that influenced their decisions to disclose, whom they disclosed to, and what was the reaction/action of the confidant. The analysis of data provided a rich description and common themes of how women perceived their experience of being abused during pregnancy were identified.

Rigor and Validity

The purpose in this study was to explore and describe the experiences of women who were abused during pregnancy. The researcher, as the instrument for data collection, used measures which would contribute to the internal validity and credibility of the study. The truth value of the data obtained from the informants was maximized through the use of open-ended questions which allowed the informants to provide answers that represented their realities and experiences, and avoid as much as possible the giving of socially desirable responses (Appendix E). The truth value was further ensured by having the informants validate the investigator's descriptions and interpretations of the data obtained in the first interview and recognize them as their own during the second interview. This process allowed the investigator to clarify and expand the data.

The biases and assumptions of the researcher were controlled as much as possible by keeping a journal throughout the duration of the research process. Field notes were made immediately following each interview to increase the accuracy of the recordings. They served as a means to examine the researcher's thoughts and feelings. This process of self-reflection on how the researcher influenced and was influenced by an informant served to minimize the threat of researcher biases and assumptions. A decision journal was kept by the researcher and served as an audit trail of plans, changes, and decisions made throughout the research process.

The interviews were tape-recorded and transcribed verbatim as a means of monitoring the researcher's objectivity in the interview. The accuracy and completeness of the transcripts were verified against the tapes prior to analysis.

Reliability refers to the consistency of information over time (Field & Morse, 1985). The credibility and reliability of the data was enhanced by the extended period of the interviews with some informants and the opportunity to clarify data during the second interview. The fittingness of the data was enhanced by the simultaneous collection and analysis of data, and the validation by secondary informants and experts who work with abused women.

The theoretical sensitivity of the researcher (Strauss & Corbin, 1990) was developed through extensive reading in the research topic area, seventeen years of varied professional nursing experience, including experience at shelters for abused women and in the area of maternity nursing. Dependability of data and analysis was further ensured by attention to the one to two hour time limit for each interview. This decreased the risk of informant and researcher fatigue. The researcher maintained ongoing communication with the Thesis Supervisor regarding data collection and analysis procedures and techniques. This consultation served to decrease the threat of making the data look more patterned and congruent than they actually were.

Credibility can be affected by the researcher-informant relationship. Feedback was sought from experts in the area of abused women which contributed to the development of a non judgmental interview approach, appropriate interview guide, and biographical data form. The establishment of trust is necessary in order for the informants to tell their true stories. As interviews lasted one to two hours and clients returned for a second interview, it appears trust was established.

Consistent with the purposes of a qualitative research approach, this study was not designed with the intent to ensure applicability to other settings or to the total population of women who have been abused during pregnancy. The informants in this study represented a wide range of experiences. Applicability of the data to the informants was achieved through thick description of the life experiences of the informants. The purpose was to discover common themes related to the experiences of the women. Two secondary informants were provided with the researcher's interpretation of the data and found the descriptions to be applicable to their experiences of being abused during pregnancy.

Ethical Considerations

Ethical Clearance

Approval for this study was obtained from the Ethics Committee of the Faculty of Nursing at the University of Alberta and the Royal Alexandra Hospital, Edmonton, Alberta. Approval to access potential informants was granted from two women's agencies. Each informant was informed that the transcribed data will be kept for possible use in a future study and that ethical approval will be sought prior to its use.

Access to Participants

Coercion to participate was reduced by the voluntary response of the informants to the advertisements (a research study telephone number was supplied on the advertisement) distributed to women's agencies and the community newspaper (Appendix A). The researcher remained sensitive to an individual's hesitancy to participate and allowed the individual the option to decline. Each participant was given the choice of being interviewed in person or via a telephone, but none selected the latter.

Informed Consent

Information was given to potential informants about the inclusion criteria, requirements, and time commitment of the study (Appendix C). Each informant was given a comprehensive explanation of the research study and questions were answered prior to the completion of the 'Informed Consent Form' (Appendix D). Information regarding the purpose of the study, the methods of data collection, and the type of involvement requested from the participants was contained in the consent form. The consent form was written at a readability index of 6.6 as indicated by the Right Writer computer program. The informants were told that they could decline to answer questions and could withdraw from the study at any time without fear of negative effects. The name and research study telephone number of the investigator was given to each informant for their use if they had any questions or concerns during the study.

Confidentiality

Several measures were taken to ensure confidentiality of informants. The procedures to ensure confidentiality of data and protection of informant identity were explained to each participant and described in the 'Information for Potential Participants' (Appendix C) and the 'Informed Consent Form' (Appendix D). All materials (audio-tapes, transcripts, consent forms, and demographic data) were kept in locked cupboards and were only accessible to the researcher. The demographic data was kept separate from the other data so no connection could be made between the informant and data. The data were identified with code names, only the investigator knew the true name of the informant. The planned use of actual interview segments, without names, in the written report was explained to each informant. Only the researcher and the secretary (for transcribing purposes) had access to the raw data. Each informant was asked when, where, and how she wished to be contacted in order to ensure the contact was confidential and she was not placed at risk of retaliation from her abuser. If an informant had disclosed information which she later wished she had not disclosed, the information would have been erased from the tapes if so desired by the informant. This situation did not occur in this study.

Disposition of Data

The data and consents will be kept for a period of seven years as required by the affiliated institution. The tapes will be kept in a locked storage area and for possible use in secondary analysis after ethical clearance is obtained.

Other

The name and telephone number of appropriate health care and other services was available for informants if the need was indicated by either the informant or by the researcher's assessment (Appendix G). One informant was provided with resource information. An additional telephone line with a research telephone number was installed in the researcher's home for the duration of the study to receive contacts from the informants. In accordance with the Child Welfare Act (R. S. A., 1980) disclosures of suspected child abuse would have been reported to the authorities. This action was not required in this study. Each potential participant was informed of this regulation and child abuse was defined as the physical, psychological, or sexual mistreatment or neglect of children which threatens the well-being or security of the child. The participant was informed that the concern would be discussed with her prior to the submission of a report. The definition of child abuse and the obligation to report its occurrence were included in the 'Information for Potential Participants' (Appendix C) and the 'Informed Consent Form' (Appendix D).

The researcher engaged in debriefing sessions with the Thesis Supervisor as needed to deal with the emotions which were felt as a result of interviewing women who have experienced abuse.

CHAPTER IV

FINDINGS

Introduction

Initially the research question asked was "What are the experiences and perceptions of women who were abused during pregnancy?" However, the womens' responses contained extensive descriptions of abuse which occurred prior to and following pregnancy. It was evident that the informants had difficulty separating the abuse that occurred during pregnancy from the abuse which occurred at other times during the relationship. For six of the women in this study the abuse began prior to pregnancy. Thus, the findings to be presented will be organized into the following major categories which emerged from the data: (a) context, including backgrounds and characteristics of the informants and abusers; (b) dynamics of the relationship; (c) types of abuse; (d) abuse and pregnancy; (e) effects of abuse on women's health; (f) interactions with professionals; (g) messages for the helping professionals; and (h) life after leaving the relationship.

The women openly told their stories of abuse to the researcher. The opening for the interviews became: "Tell me about the abusive relationship you were involved in." Considerable information relating to abuse during pregnancy was revealed, without further prompting, as the women told their stories. However, prompting was used as needed to obtain more detailed information on the nature of abuse in pregnancy.

The Informants

The informants were seven women who had experienced abuse during pregnancy within five years of the time the interviews were conducted. The seven informants were given pseudonyms to protect their identities. They will be called Amy, Beth, Carla, Deb, Ellen, Fay, and Gina. All of the women were interviewed twice except for Carla, who was pregnant at the time of the first interview. She was then hospitalized, and a subsequent interview was not possible. All interviews were conducted in person.

Description of the Informants

All of the informants had left the abusive relationship at the time of the interviews. The period of time over which the women had left the abusive relationship ranged from a few months to three years previous to the interview. Five of the women, Amy, Beth, Carla, Ellen, and Gina, had a history of more than one intimate abusive relationship. Two women, Deb and Fay, married their abusive partner when they were very young and remained in the relationship for over ten and twenty years, respectively. Two other women, Ellen and Gina, had been married to an abusive partner prior to their most recent abusive relationship. Five of the informants, Amy, Beth, Carla, Ellen, and Gina, had been in a common-law relationship with their most recent abusive partner. The women ranged in age from 24 to 37 years. The length of the abusive relationships ranged from 1 1/2 years to 20 years.

All of the women, with the exception of Amy, experienced abuse prior to becoming pregnant. She was not abused prior to pregnancy but became pregnant within six weeks of meeting her abusive partner. Amy did not relate the discovery of pregnancy to the initiation of abuse. The women had from one to four children. One woman had a therapeutic abortion. One woman had one spontaneous abortion, two had two spontaneous abortions and one had a stillborn child. All of the women reported health problems which will be discussed later in more detail. Four of the women were unemployed and three of the women were students at the time of the interviews. Four of the women had post-secondary education, one woman had high school education, two of the women had not completed high school. Income at the time of the study ranged from $700.00/month to $1,900.00/month. Five of the women were born in Canada, two of the women were born in other countries. Due to the exploratory nature of the study no specific attempt was made to include women from high income levels or different cultural groups, volunteers being accepted as they responded to advertisements and postings.

While each woman's circumstance and experience was different and unique to them, common themes were identified through analysis and are described in this chapter. Individual variations from the themes are also identified.

Context

Background and Characteristics of the Informants

The women reflected upon their family upbringing and the experiences they had within their families of origin. This was an important part of the process by which they were trying to make sense of who they had become as adults and the life decisions they had made.

Four of the informants had experienced abuse as children within the context of their families. For two women, abuse was considered a normal aspect of life and they believe this may have influenced their entering into abusive relationships as adults:

> My father was a really serious alcoholic and he was a cruel man and he was sick. . . . My father . . . started sexually abusing me when I was three and my mom knew. She would just . . . walk out (88-93 B). . . . That was how I grew up. It was normal to me (Fay, 248-249 A).

> I grew up in a very abusive home. There was lots of alcoholism. The abuse was emotional, physical. Yeah, so I think that I was used to that. You know, I didn't know any different. So my relationships that I'd been in in the past, that's all I know. Like, use me, abuse me. Because it's normal. It feels perfectly normal with me. And that's how I've been getting myself into relationships because of that (Gina, 489-496 B).

Five of the women had been in more than one abusive intimate relationship and appeared to have some insight into the reasons for this.

They recognized their need to be in a caretaker role which was established in childhood because of their dysfunctional home situation:

> I just couldn't figure out why, you know I kept meeting these men, these type of men and what was my problem. And I didn't realize it until afterwards that it was co-dependency. That I'd grown up with an alcoholic father and watch(ed) my mom try to fix him, you know, those kind of things. . . . As a woman you went out and you found an incapable, helpless man (Amy, 616-626 B).

> I'd seek out these men. I was a caregiver. They needed somebody. They needed a mother. And that's pretty much what I've been doing the last few relationships is going in and taking over, you know. I'm here, I'm going to save you guys, you know. Look after their needs instead of my own. And that's how I was raised pretty much too. I had younger siblings that I had to look after (Gina, 519-525 B).

Three of the informants talked about being very young when they met their abusive partner. They attributed a degree of naivety to the decisions they made at such a young age. In addition, the abusive partner was sometimes several years older than the informants. Because he was older the women tended to view him as the authority:

> Now looking back I was so young. I had no idea what I was getting into (Ellen, 403-405 A).

> He's quite older than me. He's seventeen years older than me (10-11 A). . . . I would be ordered around, like we had some superior there that we had to be accountable to (Deb, 592-593 B).

Three of the informants described their initial thoughts about the relationship as having met someone who would take care of them:

> I can't take care of myself. I want somebody to take care of me. So that is what ended up happening is I found somebody that took

> care of me and he got his thrills too by controlling me (Beth, 59-62 A).

> I thought that he was so much more mature. He had a job that he had been working for seven years. It just seemed like I thought that it was security at first (Ellen, 16-19 A).

> At that time like I say, I was really vulnerable. I felt he was going to come and save me from this other relationship and things are going to be so good (Gina, 329-331 A).

Six of the informants described a characteristic of their personality as having a need to please others. They often felt a high degree of responsibility to meet expectations. This need for approval led to concealing the abuse from others:

> A lot of choices were made for me and I was always the good girl and I would do what he expected of me, what my parents would expect of me, what would make everybody proud. And I have this thing that I'm the oldest child, everybody looks up to me (314-318 A). . . . That's the kind of attitude I had being the oldest and I was trained to take care of everybody else. Nobody really, really expected, said it, but I felt it was expected (114-121 A). . . . I was very obedient at home. I was a good girl. I would always try to please and get accepted (Deb, 325-327 A).

> In school I was always the one that, I was good in sports. I was always trying to please everybody and I did really well in school and so I didn't want to seem like I failed either. I didn't want to tell anybody what was happening. I wanted them to think everything was perfect and good and that was why I hid it most of the time (Ellen, 32-38 A).

> That's another reason I would have stayed with (partner) too is because my parents approved of him. I never told them what was going on. They approved of him, they saw me living out in the country, this little happy life and all that stuff. At least one of their children, you know, they didn't have to worry about me. And that's another reason why I was going to do or die. Although I knew the whole relationship was wrong (Beth, 809-816 B).

Four informants expressed feelings of self-blame in regard to the abusive relationship. Self blame tended to keep these women in the relationship because somehow they believed the abuse must be their fault. Informants would often examine their role performance and strive to improve in an attempt to make the relationship better:

> I knew that I was in this position because I put myself there, you know. I could have left a lot sooner. I allowed him to abuse me. I literally allowed him to do it to me (Amy, 1267-1270 A).

> Then I'd start blaming myself and thinking well it is my fault. It has to be my fault (Gina, 142-143 B).

> I just kept thinking it's got to be all my fault. If only I was a better wife. If only I was a better mother. So I'd just keep trying (Fay, 249-251 A).

Family Involvement

It was common for the womens' families to be unaware of either the existence or extent of the abuse with which the women were living. Only one woman, Amy, had the support of her family to leave the abusive relationship:

> They wanted me to leave him. So did everybody else. But when I explained to them I was just putting in my time, they sort of understood in a sense. . . . Yeah, my mom offered me a plane ticket to Florida, to move there (69-78 B).

Carla's father was unaware of the abuse until she called him to take her to the hospital after the final, severe abusive incident. Fear of violent retaliation from her partner prevented her from disclosing prior to this incident. She described her father's reaction: "He (father) was very upset.

He wanted to pound (partner's) face in, to put it nicely, but uh, he won't do anything because it'll mess up my case. But he was not impressed" (1177-1179 A).

The remaining five women did not seek family support. Many of the women felt they could not tell their parents. Beth knew her relationship was abusive when she contrasted it with her parents' relationship. This prevented her from disclosing to them:

> I didn't feel I could (tell my parents) because my parents have been married for over 45 years. Very nice, Christian people. I never seen my dad slap my mom. I never seen him come home drunk. I almost saw him treating her with respect and everything like that. And that's how I knew I was in an abusive situation, that this was not right, okay. Because of what I seen my parents go through (1348-1354 A).

The reasons for not telling family or friends about the abuse varied. Carla's partner threatened to harm her if she disclosed, her fear kept her silent. Deb felt she could not tell her parents for fear of hurting them and being a failure in their eyes:

> I couldn't tell my parents. And I didn't want to tell them because I was afraid if I told them, first of all it would hurt them very much and there was nothing they could do. They live very far away and then the next thing they would tell me to come back and just forget about everything. I felt responsible. I had to get a degree, get a job and you know, support my brothers and sisters and get them through life (Deb, 107-114 A).

> I couldn't tell them anything. No. There were times where he'd threaten me if I said anything, I'd get it, you know. "It's none of anybody else's business. What happens in our house stays in our house." So no, nobody knew (Carla, 197-204 A).

Four women shared their experiences of not being supported by their parents. The women's concerns were either not believed or were minimized:

> I tried to tell my parents. They didn't believe it. They didn't believe me. So what they tried to do is, "Okay we can fix her. She's this harebrained person. She's lost her mind" (Deb, 790-793 A).

> My mother was abusive, emotionally and verbally and physically and extremely manipulative. Uh, when she came up to visit me, all it did was, it was a signal and a message to shut up. Not to tell anybody. And not to make anything out of it. In fact she called it, "Somebody is making a mountain out of a mole hill." Minimizing what had happened to me (Fay, 12-18 B).

> My mom got really upset with me because she didn't like this man. She got really upset with me. And she had some of my stuff at her house and she started throwing it out the door at me because I was leaving with him. And she, at one point she gave me a black eye. . . . Haven't talked to her since. . . . So when she did that, when I got my black eye, that's when I thought, oh goodness, you know, who do I talk to? I can't depend on my family. They're mad at me (Gina, 477-500 A).

The women would also provide alternate explanations for their injuries to prevent them having to disclose the abuse to their family, as Ellen describes:

> One time he took my head and hit it on the bathtub. I had a concussion and my mom came with me to the hospital. And I told her I slipped in the bathtub. She, I don't know if she believed me or if she wanted to ignore it because she was in an abusive relationship and maybe she just wanted to ignore it (887-892 A).

Background and Characteristics of the Abusers

The informants reflected upon their partners' behavior and made reference to their families of origin. Six of the informants described their partner's background and family upbringing as abusive or dysfunctional. The family relationship might have involved physical or emotional abuse. The women believed that living with abuse as a child led directly to abusive behaviors as an adult:

> Not that I want to make excuses for him but he grew up in an extremely abusive family and I think that poem is right on, children learn what they live (Fay, 985-987 A).
>
> He came from a dysfunctional family, that made him dysfunctional. And like, on a good day . . . the dad would come in and you know the mother would be cooking and she'd say, "Get out of my fucking face you old fucker." This is how they interacted, "Shut up you spiny old bitch." That is how they interacted, you see. And that is what he learned all his life. So the abusiveness that he heaped onto me, I explained away through that, right. Oh he can't help the way he is, is because of what his parents are like. And that in some senses is true (Beth, 119-129 A).

Carla spoke of her partner as having a history of being bad tempered and quick to use his fists during disputes:

> They fought a lot. There was one time he tried to punch out his brother. . . . He's got a very, very bad temper. . . . He tried to hit his mom. I mean he's got a very, very bad temper and he needs help, but he won't go for it because he doesn't think he has a problem. . . . And his dad wasn't around either. His mom left his dad when he was seven or nine or something like that. So his dad wasn't around (971-983 A).

Deb described her partner as growing up in a family which lacked close relationships:

> They're very distant, they don't talk. . . . Everything is very private. For example he never told them we got married. Like that was private information, none of their business. . . . They're not expressive. They are not affectionate at all. . . . I understand like where it came from. . . . He had a tough upbringing, whatever. Military style life and he had been in boarding school

> since grade four and there must be something to that (677-695 A).

The women often described their partners as being nice, loving men when they first met them. In the beginning, the woman's partner was often attentive and considerate of her needs. After the relationship had begun, a change started to occur, and signs of control and abuse began to show:

> They present themselves a nice package and then when you get to know them they are hell. It is like hell on earth (1393-1395 A). . . . He was like a knight in shining armor. I had low self esteem . . . and he started with, "Tell me your problems.". . . He took me out for dinner and everything and he was very nice . . . he paid for my apartment . . . promised to help me out. He gave me cash and I thought, oh I found, you know, Mr. Right (Beth, 6-18 A).

> For the first little while he was really good. . . . He'd help with the housework. . . . He'd get a job and he was working and anything I needed he would do for me, you know, like he was really nice. I wasn't cooped up in the house all the time and he'd take me out and you know, but it started to change (Carla, 44-50 A).

Deb believed she was coming to Canada with a friend of the family who was going to assist her in obtaining an education. She was shocked by his sexual advances: "He started making advances to me and that was really shocking because he seemed such a nice guy, and so quiet and calm. I didn't think of him as aggressive, let alone sexually aggressive" (28-31 A).

The changes in their partner's behavior were confusing for the women. Because they had some investment in the relationship, it was difficult for the women to question and alter their initial judgment and perception of their partners.

Behind Closed Doors

The women described the abusers as having two different sides to their personalities. The abuser had a public persona and a private persona. One woman described it as showing "One face to the world and one face to the rest of us" (Fay, 1004-1005 B). He was selective to whom he would show his abusive behavior. The abuser was perceived as a nice man by others, but behind closed doors he was abusive to the woman. This enabled the abuser to effectively conceal the abuse from others:

> The one he took it out on was me. Everybody thought he was a nice guy, everything like this, he kept it in closed doors (Beth, 290-292 A).
>
> They didn't think (partner) was the type. Because at the office and around other people and that's why my friends didn't know. Because when we're around them he'd treat me really nice and sweet and all lovey dovey, you know, and so nobody had a clue (Carla, 373-377 A).
>
> These men . . . can hide who they are so well and they're so good, because they're actors too. Like they've had to, you know, to make things look perfect. He's very good at it (Ellen, 1261-1265 B).
>
> It's like Dr. Jekyll, Mr. Hyde. When we're around family and friends he was just so loving, and even with the RCMP and the social worker and the hospital, he's always - manipulator (sic). . . . He just had them you know. . . . But as soon as they're not around, he's just a totally different person. It was just a show. He put on a show. And it worked. It worked well (Gina, 432-439 B).

As a result of the abusers being believed instead of the women, the women described running into a closed door when they reached out for help. This caused the women to give-up trying to get assistance:

> He can manipulate people. . . . Everybody just, seemed like they always took his side. He's a nice guy, you know. . . . I think he had the RCMP convinced, you know, I tripped. It's like everybody believed him. So I think that's why I gave up. . . . I didn't say anything because nobody believes me. They believe him. They don't believe me. . . . The RCMP don't believe me. The hospital won't believe me. The social worker doesn't believe me, so. They believe him all the time (1019-1030 A). . . . Even the social worker, I asked her for help and, "No, no, no. Your partner, I talked to him. He's a nice guy and he's willing to do anything for you. He loves you so much. He told me how much he loves you and your daughter" (Gina, 144-148 B).

Dynamics of the Relationship

The No Win Situation

Several common themes were identified in the women's descriptions of the dynamics of their abusive relationships. The women tried to anticipate and prevent their partners' angry outbursts but were unsuccessful in doing so because the triggers were unpredictable. Despite the women's attempts to prevent outbursts by anticipating and eliminating the triggers, they continued to be the recipients of blame, accusations, and criticisms. Many of the women described the relationship as a "no win situation" because nothing they did pleased their partners and eventually they gave up trying to do so:

> Constant, like no matter what it was that I did, it was shit (705-706 A). . . . I couldn't do anything right. It didn't matter (528-529 A). . . . It was damned if I did, damned if I didn't. . . . It wouldn't have mattered, like it was a no win. But it was always after the door closed (Fay, 932-938 B).

> I did things to avoid getting him angry in that I made sure that I, the way I dressed when I went out, or people that saw me, that I didn't do anything wrong. Or that I didn't go places that I

> shouldn't be going. Because I was afraid that if he found out that would, that he would do something. And he threatened to take the baby, so I thought that it would give him more reason if I were to go to these places (Ellen, 1011-1018 B).

> Agreeing with him on some things or being nicer. It didn't matter if I was nice or I agreed . . . it made no difference. I tried everything. . . . I was always trying to find something. Every time I thought I had something, you know, it didn't work. I'd try something else. . . . It was unpredictable. But I did try, try to change (Gina, 457-465 B).

The women expressed frustration at their inability to influence their partners' behavior. They experienced stress and tension with normal everyday activities. In hindsight, they perceived their partners' unpredictability as a means to control them by keeping them off guard:

> As soon as he'd come home you'd be in knots. The minute he'd come home you'd be just, what's he going to say now? What's he going to do now? (Beth, 206-209 A).

> No, no, no, because as soon as I did everything he said he wanted he would change it. So it didn't matter. Never mattered. Even if I did exactly. And all I wanted was to be a good wife (Fay, 640-643 A).

> In hindsight I know it was a way to really, really keep me on my toes. Because if I knew what it was I would relax and I would do just whatever he wanted and then relax. But if I didn't know, I would just try to second guess him ahead of time, all the time (55-59 B). . . . I remember even something like eating, you would think a lot around it. Like, strategy (sic) and stress and wonder when he comes home or if he comes home or you know, like should I do this, shouldn't I do it? And it was a lot, a lot of stress just around easy everyday activities (Deb, 432-437 B).

Partners would criticize the women and blame them for any problems. The criticisms also involved accusations. The women eventually gave up trying to change their behavior to suit their partners because it made no difference to how they behaved toward them:

> Everything that went wrong was my fault and I was always to blame (Carla, 22-23 A).
>
> He would blame me for his problems, blame me for his money problems (36-37 A). . . . Stuff that I never did that he accused me of. . . . There was no reasoning behind the attacks (901-905 A). . . . I thought I would show him that I loved him, that I was different and everything like that and that just didn't work. How much can you try? After a while you just don't bother. Okay, I'm an alcoholic. Okay fine, you accuse me of being one, well fine, I guess I'm just going to drink. You accuse me of being a bad mother, well no matter what I do I just couldn't do right. I tried to prove to him that I wasn't the way he thought and then . . . it kept coming out anyway. So I just don't care (Beth, 846-855 B).
>
> I had to try and word things so he wouldn't go ballistic all the time. But pretty soon it didn't matter anyway. It just didn't matter (Fay, 1143-1145 A).

The Need to Control

The women's activities were rigidly controlled, resulting in isolation from support systems. The loss of support further impeded the women's ability to make changes in their lives. As a result of the restrictions on who they spoke to, who they saw, and where they went, the women were trapped in their relationships and disclosure about the abuse was less possible:

> He was teaching me not to make friends. You know, not get close to anybody. Nobody wanted me, nobody wanted to be friends with me. And if I get too friendly I would just embarrass everybody, including him (Deb, 139-142 A).

> Very controlling. Where I went, who I saw, what I did (404-405 A). . . . I wasn't allowed to use the phone. He took the phone right out of the wall (Gina, 765-766 A).

> I actually tried to break up with him because I couldn't talk to anybody. I wasn't allowed to speak to anybody or go out with my friends or do anything (70-73 B). . . . I wasn't allowed to answer the phone or open the door to anyone. I didn't go anywhere but to work (Ellen, 663-665 B).

> I lost a lot of friends because of him. They stopped calling, they stopped coming around. . . . My best friend and I stopped talking for about six months because every time we'd talk on the phone he'd be just within ear shot so he could hear everything. He would always listen. And every time she wanted to do something with me, he wouldn't let me (Carla, 166-172 A).

Selfishness

The men enforced rules that the women were expected to abide by. However, these rules did not apply to the men. The men regarded their needs as more important than their partner's needs. It was common for the men to come and go as they pleased, often staying out until all hours of the night and frequenting places to which the women were not allowed to go:

> He always thought about himself. He never thought about anybody else (Gina, 417-419 A).

> He was very selfish and very controlling. And nothing was okay for me but everything was okay for him, you know. Once the physical abuse started it was okay for him to go out and stay out all hours of the night, every night, whenever he wanted to. But I couldn't even go over to a friend's for an hour (Carla, 130-135 A).

> By the fifth month I wasn't allowed to go out. He drove my car. He would drive me to work. He didn't work. He would drive me to work and he would pick me up afterwards and then he'd go out at night. He would go to the casino or whatever (Ellen, 54-59 B).

Eventually, the women resigned to their partner's demands and focused on the needs of their partners rather than their own needs. Gina described her partner's jealous reaction when she attended to her own needs once she became pregnant. In response, she focused on his needs rather than her own:

> I was starting to change myself. You know, taking care of myself more instead of taking care of him. And the more I took care of myself the more jealous he would become. . . . So I would have to give him attention as much as I could, you know. Forget about myself and look after him and what he needs (469-479 B).

Jealousy

The abusers were described as jealous, insecure men who treated the women as possessions. Jealousy of the women's interactions with others sometimes led to acts of violence. To avoid conflict the women would conduct themselves carefully. Some women even took it upon themselves to increase their partner's self esteem, as Fay stated: "I wanted to build this man up because I knew he was totally insecure inside" (762-764 A). Even after the relationship ended the women's activities were monitored by their partners:

> He was very, very jealous and that led to controlling and I think that's why he wouldn't let me out of the house (952-954 A). . . . As soon as he got that (engagement) ring on my finger everything changed. He treated me like a possession instead of a person (Carla, 59-60 A).

> He would basically tell me that it didn't matter what I wanted, it was his kids, I was basically his woman, his property and he could come and go as he pleased (Amy, 122-124 A).

> "You're with me now. You don't need that." And he was really jealous and then, because I was going to go to my group one night. And he got mad and he went to the closet and he took out his gun and he was going to kill my ex (Gina, 357-360 A).

> He would phone me and say, "Who's with you?" Or come and look in my windows and even now, like last week he was asking my friend stupid questions, like. . . "Is she seeing anybody?" Like that's a big thing because it's like a possession. I can't be with anybody else (Ellen, 254-261 B).

Infidelity

The abuser's behaviors of insecurity and jealousy were often exhibited through accusations of her infidelity to him. If the women deviated from their rigidly controlled schedules the men would immediately assume unfaithfulness:

> He was so insecure about me finding someone else, you know, because of his own infidelity, that his threats always were, "If you're with anybody else I'll kill you both" (Amy, 1049-1052 A).

> He accused me of sleeping with people but he knew different because I never went anywhere. . . . If I'd be longer at the store than I had planned or whatever. . . "Who are you sleeping with now?". . . That's the first thing that would come to his mind. "Oh she's cheating on me now.". . . He's a very jealous person (Carla, 893-908 A).

> "Oh you rooked me, you rooked me real good, didn't you? You're a slut. You're a whore. It's your fault that you got pregnant, not mine. I had nothing to do with it" (Beth, 516-518 A).

All of the women were either aware of or strongly suspected their partners were unfaithful to them. For Fay, her husband's intentions to be unfaithful were clearly communicated on their wedding night and she described an incident which occurred shortly after they were married:

> I was told on my wedding night that, "It's normal for your husband to have a mistress. Put up and shut up" (10-12 A). . . . I still don't know what woke me up but I went out to the living room and they were both sitting there. They had been, God only knows what but they were undressed. . . . He was twenty-six and she was sixteen. And I was just so shocked and horrified and devastated. I mean, it's catching your husband with another woman. . . . He came in and started screaming at me. That it was my fault, it was my fault, over and over and . . . "You God damn fucking bitch. I didn't do anything wrong. It's all your fault" (83-100 A).

> He was with someone else and I think that he was two other times but I don't know. He got crabs and he said he got them from sleeping in his brother's bed (Ellen, 687-690 B).

> He said he had an affair with this black girl. . . . What ended up happening was this black hooker was hitch-hiking and he supposedly picked her up and had an affair with her (Beth, 449-455 A).

Opinion of Females

All of the informants believed their partners "had a really bad opinion of females" (Beth, 649 B). Amy and Beth attributed some of their partners' anger toward women to feelings of hatred toward their mothers:

> I don't know what his problem is. He doesn't like women. You know, he hates his mother and I think that I'm a mother role. So I think that's where his anger came from (Amy, 279-281 B).

> He associated a lot of bad stuff with his mom, you know. Like it's like a love-hate relationship I would say with his mother. . . . He hated the abuse but still loved his mother (Beth, 843-846 B).

Some of the women believed their partners were socialized to regard women as inferior to men. Examples of the men's attitudes reflected traditional, gender-specific roles:

> Females were just barefoot and pregnant and just to have fun with, but they're secondary citizens (Beth, 126-127 B).

> "You're the woman. You're supposed to be barefoot and pregnant and in the kitchen." That was his favorite one. Um, the men are allowed to go out and the woman are where they're supposed to be, staying home, that type of stuff. . . . Women take care of the kids and men don't do anything. Women take care of the kids and men go out and party, that type of thing. So he was very sexist (Carla, 1278-1284 A).

> Before I moved in he always had a maid do his housework. He doesn't do housework. He comes from a rich family and he just doesn't do housework. Never did dishes or anything and he would have a maid come in twice a week and when I came he didn't need her anymore. So I did everything. And it was really hard, especially when I was in school (Deb, 337-343 A).

Sexual Relationship

Many of the women described the abuser as very controlling of their sexual relationship. He determined when and how their sexual activities occurred. Fay described herself as naive, she did not expect the sexual relationship to be mutual or loving: "I was quite naive about sex, sexuality. Found growing up in an extremely parochial home and I didn't know, I mean I thought a woman just let it be done to her, you know. I was extremely tense" (16-20 A). Sexual relations that lacked emotional intimacy was a common theme and the women's examples reflected the depersonalization they felt:

> I didn't have a partner. I had someone that jumped me when ever he wanted. And I never got no fun out of it. That's all I had, is I was raising four children, one I was having sex with (Beth, 880-883 A).

> It would always happen at night, you know. Sometimes I would be already asleep and so. And he would climb into my bed and you know. I wouldn't even say it was making love. It was just having sex and next day he would never talk about it (Deb, 45-49 A).
>
> I was a piece of meat. I was not more than a piece of meat to be done to (Fay, 317-319 A).

The women described experiences of being forced to have sex with their partners. Often out of fear they would comply:

> There were times where he'd force himself on me for sex. I didn't want to give it to him, but. . . (Carla, 276-278 A).
>
> He actually physically forced me to have sex with him. I mean it got to the point where out of fear, I just gave in (Amy, 723-725 A).
>
> I never could get sex when I wanted it. It's when ever he wanted it. . . . When I've been sleeping, I can't stand this, he's pawing at me and I might as well just lay there and give in, because he'll paw me until I do give in. So that's what I did. You might as well say I was a prostitute, because that's how I felt. . . . He would just grope my breasts and slap them around and stuff like that and talk in a childish voice and then get on top of me and that was it (Beth, 427-441 A).

Fay spoke of the violent and degrading sexual experiences she endured in her marriage: "He was so violent, sexually violent. . . . He used to tell me, 'You bitch. You bitch.' And you know, 'You're no fun'" (184-190 A). For Fay, sexual intercourse was very painful. Her husband responded with blame rather than concern: "He used his penis as a battering ram and that's exactly how it felt. The pain was so excruciating and again of course he would say well there's something wrong with me" (197-200 A).

Beth, Carla, and Fay stated their partners were interested in pornography or strippers. This behavior continued despite the difficulties it caused in their relationships:

> He was always, like really into pornography and that. And I hated it (Fay, 316-317 A).

> (Partner) did have one addiction that caused a lot of stress between us and that was, uh, porn magazines and strippers, where he'd go and see the strippers three, four times a week. Buy a porn magazine two or three times a month or whatever. And that was one addiction that really caused a lot of stress between us because he was never home. He was over at the strippers all the time, until five in the morning, you know, and stuff, and then he'd come home and expect sex (Carla, 819-827 A).

Remorse and Promises

Abusive incidents were sometimes followed by periods of remorse. The abusers would often promise the women that they would get help and that they would never do it again - they would change. This behavior was more characteristic early in the relationship and was effective in keeping the women from leaving. The women wanted to believe the abuse would stop and were willing to help their partners. They wanted the abuse to end, not the relationship. Sometimes the abusive behavior would lessen or stop for a period of time, but it always reoccurred. Over time the abusers would typically deny that they had any problems. They took no responsibility for their behavior and were resistant to seeking counseling, even joint counseling. The women were told that they were the ones who had the problem and what occurred between them was no one else's business:

The police would come and take him away, tell him to leave me alone. And he'd be back the next day, so sad and sorry (273-275 A). . . . Then he came back from that relationship and was all remorseful and wanted to get back together. And that he was going to go get some help (Amy, 218-223 A).

Oh he would change . . . he would be like the first six months I was with him. . . . Giving me money whenever I needed it, trying to be my best friend and everything like that. And that was how he fooled me that six months (Beth, 969-973 A).

He admitted he had drinking problems. You know, he cried all night. . . . That's why I wanted to stay. He admitted he had a problem. He was going to get help (Gina, 194-197 B).

I left him. Anyway, he promised to go and get help and he promised, you know, da, da, da. The battering stopped for almost a year. And slowly but surely it came up, but it was a hundred times worse (Fay, 656-660 A).

He saw the neighbor's front door was open and he knew that they'd probably call the police, so he took off (970-972 A). . . . And he attacked me. Then of course he knew what I was going to do, so he took off. And he was gone, I didn't see him for three or four days after that (Amy, 635-637 A).

I asked to see a marriage counselor, everything, and he would say, "No. You have to change. I don't need to change, you do. There is nothing wrong with me." You know, and I would talk to him until I was blue in the face. It would change for a day and then right back (Beth, 397-402 A).

I wanted him to go for counseling. I wanted both of us to go for counseling to see if we can't, you know, work things out and see what can be done to help us and stuff like that and he didn't want to have any part of it (810-813 A). . . . He said, "No. . . . What goes on between us is that, just that, between us. . . . I don't want to go talk to anybody because it's nobody else's problems but ours" (Carla, 283-287 A).

Pattern of Violent Behavior

The women perceived that the abusive behavior increased in severity over time, as Fay stated: "It went from bad to worse" (992 A). All of the women experienced emotional abuse, and for six of the women, the abuse escalated to physical violence:

> It just got progressively worse from there. It started out first as verbal and emotional abuse and then it went to physical (11-13 B). . . . He'd put me in the hospital twice near the end. Where before it was just you know, pinch or a bite or a slap or whatever. I mean that's still physical abuse but it got worse near the end (Carla, 997-1001 A).

Amy believes that if she had taken measures to stop the abuse in the early stages of the relationship it would not have escalated to such a severe level. Her partner's ability to behave in a manner that resulted in no negative consequences for him facilitated the continuation of his abusive pattern of behavior:

> It got worse, progressively got worse and he got angrier and more violent. It seemed like because he got away with it once, he was going to get away with it again and again and again. And his threats got worse. At one time when I was pregnant with the child that I aborted, he had pulled a knife out and said he was going to kill me and the kids and himself (1012-1021 A).

As the women became stronger and more resistant to their partners' control over them, the abusers responded by becoming more controlling and more abusive. Instead of promises and remorse, fear of violent retaliation was used to keep the women from leaving:

> What he liked was this innocent girl that looks up to him like God and he can teach me everything and I'll just say, "Yes" and be

> happy. And then I started to have my own opinion and sometimes say, "No" and do things my own way, be sociable, which he didn't like that. He didn't like that at all (Deb, 277-282 A).
>
> That was one of the things that was helping to escalate, the more help I got for myself and the kids, the more I was butting up against this control thing of his. The more violent he was getting because that was the only way (Fay, 1138-1142 A).

Amy's awareness, that she was at an increased risk for violent retaliation with each step she took to leave the relationship, resulted in a fear which immobilized her from laying charges against her abusive partner:

> Threats got worse. The farther out of reach I got from him, the more violent he got. . . . My fear for charging him is because the stronger I got and the farther away I moved, removed myself from him, the more aggressive he became in trying to keep the relationship together (1083-1088 A).

Although each woman's background and abusive relationship was unique, commonalties in their experiences were apparent. The women's personalities tended to reflect self-blaming and the need to please and be accepted by others, often at great expense to their own happiness, which is indicative of low self esteem.

The abusers also shared common personality characteristics. They were described as insecure, jealous men who took great measures to control the women. They were often successful in manipulating others by maintaining a public and a private persona. Several of the women and abusers had experienced abuse as children which supports the theory of the cycle of abuse. As the women became more resistant to the abusers' controlling behavior, the efforts to control them increased. All of the women experienced an escalation in the severity of abuse over time.

Types of Abuse

The women in this study experienced various forms of abuse. The forms of abuse that were identified included both emotional and physical aspects. Emotional abuse was often verbal and could include financial parameters. Physical abuse could include physical harm to the partner or could be sexual in nature.

Emotional Abuse

The women in this study were threatened by their abusive partners and this was used to gain control over them. As Beth stated: "He threatened and threatened and threatened, and just to keep power over me" (988-989 B). In hindsight, Fay was able to associate her feelings of fear with her husband's threats: "I was scared. And I didn't realize it until afterwards, it's because he was constantly threatening me" (849-852 A).

Beth, Fay, Amy, Carla, and Ellen reported receiving verbal threats of physical injury from their abusive partners:

> He threatened me. . . . "I'll slaughter you. I will smash your head in. I will knock your teeth out.". . . You know, vicious things, usually to maim me (Amy, 1037-1047 A).

> He was threatening to kill me one time and if I tried to take the children, definitely he would kill me if I ever tried to leave (Fay, 523-525 A).

Carla's partner ensured her silence about the abuse by threatening to physically harm her:

> There were times where he'd threaten me, if I said anything I'd get it, you know. "It's none of anybody else's business. What happens in our house stays in our house" (201-204 A).

Ellen's partner threatened to harm her with the intent of harming the fetus if she ever became pregnant:

> He used to say . . . "If you get pregnant . . . I'll push you down the stairs" (412-414 B).

The threats of physical injury were also in the form of actions. These threats were commonly used to maintain their position of power over the women, to punish them, or to coerce them into acting in a certain manner:

> He'd take the door and . . . pretend to hit me in the head. . . . He pretended one time to push me down the stairs. . . . He took my arm and I was pregnant and went, "Ha, ha, ha, ha." And he shoved me. And I was going . . . down the stairs and he grabbed me by the wrist. But I can still remember the terror, and the kids were watching (Fay, 854-863 A).
>
> He picked up a chair and he was going to throw it at me. You know, he came towards me like he was going to strangle me. He was so angry (Gina, 1096-1098 A).
>
> He put me in his car and took me out to the country and he said, "See where we are? . . . I could leave you out here and nobody will know where you are, that you're with me." Because he was just trying his last attempts to see if I would have an abortion (Ellen, 397-402 B).

To intimidate their partners, the men used abusive threats which often centered on loss of custody of their children. The men would use accusations such as infidelity, incompetent mothering, or mental instability:

> He threatens you with whatever means the most to you, and that is usually a child (1443-1444 A). . . . He would say, "If you leave me I am taking the kids away from you because you are no good for nothing. You are not even a good mother" (Beth, 93-96 A).

> He was going to get custody on account that I was a slut and I was a prostitute and I was sleeping with all these people. And he can have witnesses who have seen me with this guy, with this guy, with this guy. That was going to get him custody (1415-1419 A). . . . He has always threatened me. . . . He had threatened to make sure my parents won't even come. He has threatened so many things, whatever would work. . . . He then started threatening me about my daughter. He was going to take her back to (another country). I wasn't a good enough parent (Deb, 1311-1317 A).

> (Husband) said, "You're paranoid, delusional.". . . All this terrible stuff to have the kids taken away from me (Fay, 565-568 A).

> I came there severely depressed again because I'd gotten off the medication and I told her (doctor) also my husband had pushed me to get off it because he said, you know, I'm this drug addict . . . and he threatened me a lot of times. He says I'm a nut case and when he takes my kid he'll prove it that I can't function. . . . I can't function mentally so they'll put me in the hospital (Deb, 357-364 B).

The threat of losing their children kept the women in the relationship, despite their recognition that it was dysfunctional:

> You feel you have to stay in that relationship because you want your kids, because these type of men, they threaten you all the time, "We're going to take your kids away from you" (Beth, 152-155 A).

All of the women reported being emotionally harmed by the abuse they endured. Although each individual experience was unique, common examples of the types of emotional abuses endured include insults, withdrawal of affection, and punishments. Actual behaviors included lack of expressed affection and emotionally distancing behaviors. The abuser would also engage in activities which were directed toward deliberately hurting their partner:

> He hated me. He would say, "You know, I hate everything about you. Everything" (310-311 A). . . . Never once in all the time . . . for twenty years that we were together, I never remember him saying, "You look nice." Never once (Fay, 140-142 A).
>
> He would never tell me he loved me. I never looked nice or anything like that. I would have to force it out of him anyway. . . . He would say things like, "Yeah, I'd take you out if you got skinnier." I asked him one time what his fantasies were, he said my girlfriends (referring to Beth's friends) (Beth, 135-140 A).

Emotional distance was identified by informants in the following way:

> He would not touch me at all. He wouldn't even look me in the face most of the time. And he started drinking heavily and just never being there. Going out until three or four o'clock in the morning. I would sleep alone most of the time (Deb, 477-480 A).
>
> My dad was diagnosed with cancer of the bladder, so there was a lot of emotional turmoil and my husband was totally nonsupportive. And I mean none whatsoever. And it was a really difficult time and there was absolutely no emotional or physical, like no kind of help or support in any way, shape, or form. Like, "You're on your own and don't complain" (Fay, 60-66 A).

Ellen's partner killed one of her cats and harmed her other cat. She believes he chose to do this because he knew it would hurt her deeply:

> I had the cat since I was in grade five. I had it for sixteen years. . . . Because he knew that I loved that cat. It was a way to hurt me. He knew. . . . That was just a way to hurt me and he knew that that was the worst way (602-625 B).

Gina talks about her experience when she was in hospital giving birth to a stillborn daughter:

> He took (baby's) stuff and wouldn't give it to me. He took my daughter. When he lost (baby) he took my four year old daughter and he didn't want to bring her back. And he had me worried all the time I was in the hospital. . . . I worried, where is she? Where did this man take my daughter? . . . That was really hard to go through, you know, I'm looking all over the place for my daughter and my one daughter has passed away here and where's my other daughter? (1110-1122 A).

The partner's behavior was often perceived as punishment or uncalled for aggravation:

> He was emotionally abusive, mentally abusive. . . . He would punish me . . . if I did something bad he would punish me until he saw fit that the punishment was over by calling me names, by telling my children that I was nothing but a drunk, a slut, a whore (Beth, 88-93 A).

> He'd wait until I'd finally just relaxed or start to try to relax in the bath or something and he'd come tiptoe up and he'd just pound on the door. Some people might think that's funny but it's not. When you're so exhausted and you're sitting there with your head in your hands anyway, you know. Like, be it in the tub or just sitting on the edge of the tub and then, "What are you doing? Picking your face? Picking your nose? Playing with yourself?" You know, like, can't I just have a bath? (Fay, 440-449 B).

The repetitive nature of the insults and ridicule had a lasting effect on how the women viewed themselves. All the women commented on their increasing low levels of self esteem:

> Everything was my fault, and he would tell me that. No matter what it was. I was a piece of garbage. I was a retard. I was a whore. I was nuts. I was crazy (Fay, 483-486 A).

> He'd say, "Why don't you ever use that brain of yours?" Or, "What are you, stupid? Don't you know how to do it this way?" Or he'd call me fat, and he'd call me lazy and stupid and a bitch and a whore and a stink and a few other words I'd rather not mention (Carla, 120-125 A).

Ellen believed her academic success made her husband feel inferior:

> My lowest mark was 86 in biology and he would tell me how stupid I was, I wasn't working hard enough. But I was. . . . I think he wanted me to do good, but yet it made him feel like he wasn't as good. So he had to put me down to make me feel bad (328-334 A).

Financial abuse was relatively common. Withholding money acted as a form of control as it limited the women's activities and reinforced their feelings of decreased worth. Financial constraints acted as barriers to the women leaving the relationships. Beth noted: "Who ever has the money has the power and they use that power" (345-346 A). It was common for the women to have to ask their partners for money:

> I never had a chequing account. I didn't have access to his cards or anything. If I wanted money I had to ask him, "Could you give me twenty dollars?" And he would say "yes" or "no". And I would have to explain why (Deb, 530-533 A).

Lack of financial resources made the women dependent on their partners, which in turn reinforced their feelings of lack of worth:

> I couldn't really do anything, go anywhere, I didn't have the money. I had to depend on him (Gina, 236-237 B).
>
> He would use that money all the time against me. . . . When he was feeling bad he would make sure that I would know where the money came from and who was supporting me and the kids. . . . "Without me you are nothing" (Beth, 349-354 A).

In Fay's case, her husband did not always financially support her and their four children, leaving them destitute for long periods of time:

> He always made sure that I had no money. No money at all. He would go away for like long periods of time to work and leave me without any money (322-325 A).

Physical Abuse

Deb was the only informant in this study that did not experience extreme forms of physical abuse: "He restrained me from going once, from leaving the house. Like he would hold my wrists but I didn't even feel threatened by it that much" (1456-1458 A).

Carla talked about how she initially did not recognize the physical abuse as abuse:

> The start of the physical abuse I thought was just fooling around. He would bite and he would pinch and wrestle a lot. And I thought it was just his way of goofing around. But in actual fact it was physical abuse, where he left marks on me and I told him to leave me alone and he wouldn't (271-276 A).

The abuse Ellen experienced was usually kept hidden from other people. She stated that it was not common for her children to be present when he was physically abusive to her and recalls an incident when they witnessed her being physically abused: "He hit me in front of my kids. . . . Usually he never did anything in front of my children" (163-165 B).

Amy's relationship involved repeated episodes of severe physical abuse: "He'd grab my hair or throw me around, choke me, that was one of his favorite things, choking me" (266-268 A). For Amy, the abuse occurred in both private and public settings: "Next thing I know he'd got me by the hair, dragged me into the middle of the parking lot and started kicking me. . . . Then he ripped out wads of my hair, and I'd lost a couple of toenails because I had a pair of sandals on, he stepped on my feet and dragged me" (765-783 A).

After Amy left her partner, he continued to break into her home and physically assault her:

> He broke in through the basement and was kneeling on top of me and he had me . . . on the forehead by the hair and was just slamming my head into the ground. And I had a little sundress type thing on . . . he was accusing me of sleeping with somebody else and . . . he ripped it right off and he ripped my vagina open (954-964 A).

Carla described the abusive episode that resulted in her hospitalization and the termination of their relationship:

> He tried to hit me in the stomach. . . . I had a concussion and I had a bruised chest bone. I still have marks on me from him. He'd pinch and he'd scratch and he'd hit (261-264 A).

The physical abuse experienced by the women in this study varied in severity, type, and setting in which the assault was inflicted. However, an escalation in the severity of abuse over time was a common finding in each woman's situation.

In summary, all of the women experienced a variety of forms of abuse which included emotional, financial, physical, and sexual abuse. The common thread which binds the women's experiences is the perpetrators' use of abuse in an attempt to gain or maintain power and control over the victims.

Abuse and Pregnancy

Although the women in this study experienced abuse prior to and following pregnancy, they were able to share their perceptions of the effect pregnancy had on their abusive relationships. The effect of pregnancy on the relationship varied with each woman's situation. One informant experienced a decrease in the severity of abuse during one of her pregnancies, but more commonly, the abuse inflicted increased during pregnancy. Five women reported a change in focus with the abuse directed toward the pregnant state or the unborn baby. For two women, the abuse did not change in focus or intent during pregnancy. The abuse continued during the vulnerable period of recovery in the immediate post-delivery phase for some women. The women's stories included experiences during the antepartum, intrapartum, and postpartum periods.

Onset of Pregnancy

For most of the women in this study their pregnancy was not planned. "I didn't want to have children. At that point I knew that I wasn't going to get pregnant" (Deb, 177-179 A). Some of the women were using birth control methods to prevent conception. "We used condoms and I was very religious about it. It worked for three years, so I had no reason not to think that it wouldn't work (Deb, 365-371 A). Ellen had been involved with two abusive partners. She started to use contraception when she realized the relationship with her boyfriend was becoming abusive: "I started to take the pill because I thought things were getting really bad. He was starting to get really abusive and really controlling" (138-140 B).

For several of the women the pregnancy occurred early in the relationship. "We became intimate very quickly and within six weeks I was pregnant" (Amy, 13-14 A). Gina married her boyfriend because she had become pregnant: "We hadn't known each other very long and I got pregnant. And I decided to get married because of the pregnancy" (8-10 A). Ellen and her husband were married within a few months of meeting and she became pregnant soon after they were wed: "Two months after we were married I found out that I was pregnant" (155-156 A).

Becoming Pregnant - Relationship to Abuse

When they became pregnant, the women hoped the abuse would stop and the situation would improve. "Now we have a baby and he'll change and we would have a happy family" (Deb, 224-225 B). Gina wanted the relationship to work because she wanted a family and believed her partner wanted a child:

> I should of left. Should of, could of, but at the same time though, I was, I don't know. I was pregnant, you know. I don't know, I wanted a family. You know, this is his first baby. He really wanted this baby, really bad, so . . . (190-194 B).

In addition to hoping that having a baby would improve the situation, Gina was pressured by others to maintain the pregnancy:

> I told him I wanted to have an abortion. He got really mad, really mad. But I don't know, as time went by, you know, I thought, okay, things are looking good. And he'd talk to me and his

> mother talked to me. . . . And everybody was so excited, you know, so I thought, okay (606-611 A).

To cope with the abuse Fay would pretend the situation was different than it was, this involved denying and covering up the severity of the abuse:

> I had to create what I wanted. What I wanted to believe, you know, the dream. Everybody's dream, the perfect family . . . a loving family. I didn't intentionally lie but I wanted it so bad that I would say, "Oh, no, he's a pretty good guy" (658-663 B).

Beth perceived pregnancy as a factor which made it more difficult for her to leave her abusive partner:

> But now because I was pregnant I couldn't get away (290-291 B). . . . I knew this wasn't the relationship for me. Now, you know, when I am pregnant and stuck with this kid, and I'm stuck with him now (580-582 A).

Amy had stayed with her abusive partner as she believed it necessary for the safety of her children, with the intention of leaving when the children were older:

> I basically gave up. Gave up. Okay, I'm going to put my time in, when my kids are old enough to tell me what's going on then I'll leave, because I'll never be able to keep him from the kids. They were quite little and I was afraid that if I left . . . if I just let him take the kids that they would be abused or neglected. And they wouldn't be able to tell me that was going on. So I made this decision that I was just going to put my time in with him and that when they were old enough, then I would, you know, stay away from him and let him see the kids, you know. Just for our own safety (732-748 A).

This led to her decision to have a therapeutic abortion because she believed another baby would prolong the amount of time she would have to stay in the relationship. Deciding to terminate the pregnancy was a very difficult and painful decision. Amy believed it was her only option, a necessary measure to take in order to achieve a life without abuse for her children and herself:

> I didn't want to have the abortion. I knew that it was one of the only ways I was ever going to get away from him. . . . I knew that if I had another baby it would just prolong my putting my time in (860-867 A).

Reaction to Pregnancy

Many of the women had strong reactions to discovering that they had become pregnant. Generally, the pregnancies were not only unplanned but also unwanted. The effect of the abusive relationship on the women's feelings toward pregnancy were dramatic. The women questioned what was right and wrong as they sorted through their feelings. Some women made decisions which under normal circumstances they would not entertain.

Most of the women did not want to become pregnant. A common reaction was denial. Deb described feeling very anxious as she awaited the test results from her physician: "I thought I had cancer, you know, like I had just had anything but pregnancy" (398-399 A). Gina was very upset when her physician informed her that she was pregnant:

> I was in shock. I remember I told the doctor too, I said, "No, no, no. I didn't want to be. No, no, no. No this can't be happening." After all the stuff we went through, you know, I can't be pregnant (594-597 A).

Some of the women were so distraught with the idea of being pregnant that they denied the pregnancy. "I was in denial, there was no way I was going to be pregnant" (Deb, 383-384 A). Ellen denied that she was pregnant even up to the time of the birth:

> I was so exhausted when I was pregnant. I was really into denial. Like when I was in labor, after I was given the morphine, I remember asking why I was there and they said, "You're having a baby." And I said, "No I'm not. I'm going to school." Like I had totally denied that I was pregnant (1217-1222 B).

Because the pregnancies were undesired, many of the women wanted their pregnancies to be terminated. They were faced with making decisions which involved an examination of their morals and values. The pain associated with this process was evident in their descriptions. Some women hoped the pregnancy would be spontaneously aborted and some women considered having a therapeutic abortion:

> During the whole pregnancy I didn't care. . . . When I was bleeding with (daughter). . . I told a friend of mine, "Well if I am aborting, you know, miscarriage, it would be better for the whole way around" (572-576 A). . . . I considered having an abortion, but because I am so much against it, right? To me it is like murder, so I didn't. But I wanted to. I wanted to so bad (Beth, 601-603 A).

Amy decided to have a therapeutic abortion: "I told him I was pregnant and that I wanted to have an abortion" (753-754 A). She had regrets after the pregnancy was terminated: "I felt terrible, you know, I figured I'd made a mistake and you know, it was pretty awful. You don't have three kids and have an abortion and not feel bad about it" (407-409 B).

When Gina was married to her abusive husband she wanted to terminate her second pregnancy:

> I was so sick and I remember I felt so bad that I went to the doctor one day and I told him, I think I was about four and a half months pregnant, I told him I wanted the pregnancy ended. I was just so sick and I wasn't getting any help. I was just stressed (67-71 A).

Gina also wanted to terminate the pregnancy that occurred when she was with her abusive common-law partner: "He wanted my reaction to be happy and I wasn't happy at all and I told him I wanted to have an abortion" (605-607 A). She was convinced by her partner to maintain the pregnancy.

Although Deb did not want to be pregnant, she was hurt by her husband's insistence that she have a therapeutic abortion. His response made her feel that having an abortion was the best decision. It was Deb's friend who convinced her to maintain the pregnancy, but Deb continued to hope she would spontaneously abort the fetus:

> He wanted me to have an abortion, I'm going to have one because I should be crazy to want this baby now (518-520 A). . . . I went to the doctor lots of times because I was afraid that I was, not that I was going to lose the baby, that didn't bother me that much, you know. And I didn't want to cause it, but if I lost it, it wouldn't be that bad (463-466 B).

Each woman made decisions to the best of her ability based on her unique situation. At the time of the interviewing they were continuing to work on the feelings of guilt associated with their thoughts and decisions related to their pregnancies.

Some of the women described the contrast between their feelings toward the unborn child during a wanted pregnancy and an unwanted pregnancy. They candidly described their difficulty in loving and emotionally connecting with the unwanted child, a stark contrast to the attachment they felt toward a wanted child. Beth's experience supports this phenomenon:

> When I carried (first child) I looked forward to holding the child and everything like that. I was more at peace with myself. It was the happiest time of my life. And with (second child) and (third child) I didn't look forward to holding them. I had horror. I didn't want to be pregnant. I was miserable the whole time I was pregnant, on edge all the time, emotional roller coaster, nothing like (first child). With (first child) I was touching it and everything like this (793-800 A).

Beth further explained how her abusive situation resulted in feelings about the pregnancy which affected her attachment to the unborn child: "You are not loving that child inside, because you don't want it, because you are going through so much shit and you are stuck in this situation you don't want to be in" (832-834 A).

Ellen had difficulty bonding with her unborn child. She was concerned about the effect stress would have on the well-being of her child and her husband's reaction to the pregnancy. Ellen's fear of getting close to the baby may have been a form of self-protection against the hurt she would experience if her child did not survive. Her feelings toward the child were also influenced by her partner's disapproval of the pregnancy:

> I thought maybe something was wrong with my baby. . . . I found that it was a lot harder bonding. Just even when I was pregnant it seemed like I was afraid to get close. I think because I thought maybe something was wrong and because of his reaction too (115-124 A).

Abusers' Reaction to Pregnancy

The abusers had a variety of reactions to the women's pregnancies. Two of the men expressed a desire to have the child and vehemently opposed the women's wishes to terminate the pregnancy. Four of the men did not want the child and directed the women to terminate the pregnancy or took actions to cause the pregnancy to be aborted. Other men denied paternity, accusing the women of being unfaithful.

Two of the abusers were happy that the women had become pregnant and reacted with anger at the women's desire to terminate the pregnancy. Amy wanted to have a therapeutic abortion, she described her partner's reaction: "He didn't want me to have the abortion. He was quite angry" (931-932 A). She believed her partner wanted to have children: "He wanted children. . . . He wanted to be a good dad, because he never had a dad" (282-287 B). Gina's partner was also opposed to her having an abortion: "I told him I was pregnant. He was really happy. He was so excited . . . and I told him I wanted to have an abortion. He got really mad, really mad" (603-608 A).

Five of the abusers did not want the child and attempted to convince or coerce the woman into terminating the pregnancy. One man directed physical abuse toward the unborn fetus in attempts to terminate the pregnancy. Three of the men were initially supportive of the woman getting pregnant but when the pregnancy occurred they were angry, as Fay describes:

> I was using natural family planning method. I mean, I told him, like, "We'll conceive. I mean, we're not going to miss." "Doesn't matter." And I said, "Well remember that." And when the test results came back that I was pregnant he just went ballistic. He was enraged and I was so shocked and devastated and hurt (780-785 A).

Ellen experienced similar reactions, first with her abusive husband and later with her abusive boyfriend. Ellen's partners initially were in favor of her becoming pregnant, but once she became pregnant they no longer wanted a child:

> He (boyfriend) kept saying, "Well I want a baby. I want a baby.". . . But when I got pregnant, I don't know if he really wanted me to get pregnant. Like sometimes I think it was just like a control type of thing because as soon as I was pregnant, first of all he didn't believe me and then when he knew, he didn't want me to have the baby (135-154 B).

Although Deb did not want children, she was devastated by her husband's insistence that she have a therapeutic abortion:

> He said, "The best thing to do is you just have an abortion, because we can't afford children and you have to do your education." It's not that I really wanted the pregnancy or not that I really wanted the baby. . . . That was really, really hard. And I just lost it. I remember sitting on the floor in the bathroom and locking myself in for hours and hours and hours. I have never sobbed so loud (432-442 A).

Carla's boyfriend did not want to be a father and made several attempts to terminate the pregnancy: "Because of the fact that he didn't want to be a father, he did everything in his power to make me lose it" (1013-1014 A). Carla's boyfriend directed physical abuse toward the fetus.

Beth's partner accused her of getting pregnant as a means to trap him into marrying her: "I found out I was pregnant with (daughter) and that is when it really started. . . . I rooked him into being pregnant with (daughter) to get him to marry me" (31-43 A).

The abusers were described as jealous men who would accuse the women of infidelity. With the occurence of pregnancy, it was common for the abusers to deny paternity:

> He tried to accuse me that (daughter) wasn't even his. . . . He implied that I went out and screwed around and (daughter) wasn't even his (Beth, 519-522 A).
>
> "It's probably not my baby. You're probably only a few months pregnant.". . . He kept telling everyone, "If it's not born in November it's not my baby. It can't be my baby" (Ellen, 653-657 B).

The funeral arrangements for Gina's stillborn daughter were delayed by her partner's request for paternity tests. Gina believed this was done to purposely hurt her:

> All I needed was to have (baby) released from the hospital to the funeral home. My ex phoned my doctor and put a hold on it. He says, "I want a paternity test. I want to see if this is my baby" (1205-1208 A).

Pregnancy added an additional stress to the abusive situation. Their partners' reactions to pregnancy were varied and greatly influenced the women's thoughts, feelings, and ultimate decisions with regard to the pregnancy.

Effect of Pregnancy on the Relationship

The women reported that the pregnancy had various effects on their abusive relationships. For some women the abuse escalated in pregnancy, for one a decrease occurred. The pregnancy had an effect on the sexual relationship, some partners became unfaithful; others merely refused to have sex once the pregnancy occurred. The findings suggest an element of punishment for becoming pregnant as if it was the woman's fault.

Some of the women believed the abuse increased in severity as a result of the pregnancy. Deb, Beth, and Carla believed the pregnancy made the relationship with their partners worse:

> I know truly in my mind that the abuse got worse during pregnancy (Deb, 768-769 B).

> When I was pregnant with (daughter) he abused me for seven months . . . he punished me for seven months (Beth, 889-891 A).

Carla believed the nature and focus of the attacks changed in pregnancy, becoming more severe and directed toward the fetus:

> When we found out I was pregnant the physical abuse got worse. . . . He was always wrestling with me but it was always directed at my stomach. . . . The last assault that caused the charges against him, where he tried to actually punch me in the stomach, made me realize that he just didn't want this baby. So yeah, the baby, the pregnancy did change a lot (1022-1029 A).

Fay described how the verbal abuse changed in focus and how it became directed toward her pregnant state:

> "Oh, you're fat. You're big and fat." And he was going to make me run behind the truck and comments to that effect" (48-50 A). . . . A whale, he used to call me a beached whale all the time. He was disgusted. I was disgusting to him" (386-388 A).

Ellen was the only informant who believed the abuse she received from her husband lessened during pregnancy: "He wasn't as physically abusive during the pregnancy. I think because he came to the realization that he, you know, that he could hurt me and that something could happen" (38-41 A). However, in a subsequent relationship with another abusive partner, Ellen reported an increase in abuse during pregnancy.

Four of the women described how their sexual relationship was affected by the pregnancy. Commonly, the men withdrew physical contact and refused to have intercourse with their partners once they became pregnant:

> He refused to have sex with me and he said, well it's because he doesn't want to hurt the baby. . . . I asked him, "Let's go to the doctor, he'll tell you himself there's no problem" (Deb, 469-473 A).
>
> Ever since I found out I was pregnant he didn't want to, we never slept in the same bed at the same time. He didn't want to touch me, he didn't want me to touch him. Nothing (Carla, 838-841 A).

Focus of Abuse During Pregnancy

During the pregnancy, two of the women experienced abuse that was directed toward harming the fetus. When Fay's husband was sexually violent she believed he was trying to terminate the pregnancy. Eventually, she was hospitalized for abruptio placenta following an episode of violent intercourse:

> He hated me for being pregnant. Sex was a nightmare and I knew he was trying to cause me to lose the baby, I knew it (808-810 A).
>
> I ended up in the hospital because I was pregnant and he tried to hit me in the stomach . . . he was trying to kill the baby and I have witnesses to him even saying that (Carla, 260-266 A).

In contrast, the abuse inflicted upon Amy during pregnancy was never directed toward the fetus: "He hit me, he spanked me actually, is what he did. He punched me sort of in the butt, but not in the abdomen. Never" (305-307 B).

There was also a belief that the partner was jealous of the fetus because the woman's attention was no longer focused solely on him. Gina describes the way her partner reacted when she began to focus on caring for herself and her unborn child by trying to eat a healthy diet and ensuring she was getting adequate rest:

> The more I took care of myself the more jealous he would become. And that's what I find with the pregnancy. He wanted a baby really bad but as soon as I started taking more attention away from him and putting it on myself, on my body, on my baby, and my health, it's when he started getting angry because he wasn't getting that attention anymore (470-476 B).

Carla described her partner's jealously of the newborn baby. He expressed his anger through his rejection of the child. His continued demands on Carla reflect a lack of empathy regarding her needs for recovery:

> Very jealous of my youngest one, because being a new mom again, all the attention went to (baby) and none went to (partner) you know. Whether it was sex, or whether it was cuddling. . . . I was tired all the time, because I had a cesarean section. . . . (Baby) took a lot out of me and I had no energy to go out. I had no energy to have sex. I had no energy for anything. . . . He got really mad because he figured, you know, "I'm part of this family too and where is my attention?" And I just didn't have the energy to give it to him. So after that he had nothing to do with (baby). He didn't want to play with him. He didn't want to hold him (555-569 A).

No Change in Abusive Pattern During Pregnancy

Three of the women believed the abuse would have occurred regardless of the pregnancy. Although Beth believed the abuse increased with pregnancy and her partner punished her for being pregnant, she also believed he would have been abusive regardless of the pregnancy: "He would have been abusive whether I was pregnant or not" (285-286 B).

Amy indicated that her partner's abusive behavior was unaffected by her pregnancy: "It didn't make any difference to him whether I was pregnant or not. He was just a mean person" (262-264 B). Amy experienced severe forms of physical abuse throughout her pregnancy: "He got out of the van and grabbed me by the throat and threw me down to the ground and at that time I was about, you know, five or six months pregnant" (103-105 A). In contrast to most informants, where abuse generally occurred in private, Amy was also abused in public settings during her pregnancy:

> He grabbed me by the hair, this was his famous thing to do was grab me by the hair in public. He did it all the time and he literally

> dragged me out of the bar. We went up the stairs into the foyer and he grabbed me by the shoulders and pushed me so hard I hit the concrete wall and passed out. And the next thing I remember is two bouncers standing there and him saying, "Oh she's just had too much to drink." And here I am seven months pregnant and he's just humiliating me (165-173 A).

Two of the women experienced severe forms of physical abuse in the immediate post-delivery period. Gina described the abuse she experienced while hospitalized following the cesarean section delivery of her stillborn daughter:

> I think that's the worse abuse I received from him, would be on her death in the hospital. . . . He pushed me on the couch. And he was going to grab for the TV and then he didn't. Then he started pounding on the floor, jumping up and down. It was like he was losing it and then he picked up a chair and he was going to throw it at me (1143-1158 A).

Amy was physically abused by her partner in the immediate postpartum period upon return home from the hospital:

> He grabbed me by the hair and by the throat and pushed me up against the fridge and slammed my head into the fridge. My little boy is standing there watching. . . . And I just felt a gush of blood, like I'd passed a huge blood clot. . . . And I just fell to the floor and I was just mortified that he had done this, I mean I'd just had the baby and he attacked me (621-635 A).

Abuser's Type and Degree of Involvement with the Pregnancy

The abusers exhibited various types and degrees of involvement during the informants' pregnancies. Examples of the abusers' behavior during the antepartum, intrapartum, and postpartum periods will be discussed. A common theme was minimal involvement of the abusers. Pregnancy was viewed as the women's problem. Attempts by the women to involve their partners were unsuccessful:

> When I was pregnant he really didn't get too involved (Ellen, 136-137 A).
>
> It's not his problem. It was my problem. He didn't want it (516 A). . . . All these nine months I kept on asking him, "What are we going to call the baby?" "Oh, I don't care, do whatever you want." He never wanted to have any part of it (Deb, 1038-1041 A).

The women reported disinterest and a lack of empathy from their partners during the antepartum period. Generally the abusers did not attend prenatal classes or physician appointments. One woman's partner however, would not allow her to be alone with the health care professional. Gina's partner insisted on being present at all of her doctor's appointments. She believed his presence was motivated by a fear of her disclosure rather than an interest in the pregnancy:

> Throughout my pregnancy my ex always had to be at the doctor's visits. I could never go alone. Never go alone. He'd always have to be in the room. Always. I think maybe he was afraid I was going to say something like, "My ex, you know, he threw me down." Or, "He's been physically abusive towards me through this pregnancy" (1000-1110 A).

In contrast, Carla's boyfriend did not want to go with her to the doctor's appointments:

> The visits, he went to but he didn't want to, like, he had to drive me there so he had no choice but to go. But other than that he didn't really care about how the baby was growing . . . or if the baby was developing normally or anything. He went because he had to drive me and that was it. In the beginning of the

> pregnancy with this one it was to the point where he didn't even go to the doctor's with me at all (599-609 A).

The abusers were often reluctant to attend prenatal classes. When they did attend it was only at the women's insistence:

> I went to prenatal classes. I dragged him there. . . . I said, "I won't talk to you anymore. You have to come." So he came to a couple, like two out of six maybe (Deb, 913-920 A).

> He went to prenatal classes because I made him (Ellen, 188 A).

The women talked about their partners' lack of empathy for how they were feeling during the pregnancy. Common physiological adaptations, such as fatigue and nausea, were not tolerated:

> Sometimes I would take a nap in the afternoon, he'd come home and wake me up . . . he'd poke me, "Get up. Now! You're so fucking lazy." This is while I was pregnant (Beth, 557-562 A).

> Even when he cooked I had to leave because . . . I just couldn't smell the food and he got really, really upset at that. . . . I couldn't even swallow my own saliva so I took a cup and I would spit it out in the cup and I would keep it at my side. And when he saw that, he took that cup and smashed it against the wall (Deb, 499-506 A).

Five of the women stated their partners were unsupportive during their labor and delivery. The men were often reluctant to be present, spending minimal amounts of time with the women. The birth process was viewed as an inconvenience that did not warrant interruption of their work or daily routine. These findings suggest that a lack of presence and/or support from the partner may be a warning sign of abuse. Many of the women did not view their partners as a source of support but rather viewed their presence as an additional stress that they would have to cope with in addition to the labor and delivery process:

> He was working and this was an inconvenience, he was going to have to drop me off at the hospital (Fay, 907-909 A).

> He didn't miss a beat during my labor and delivery. I remember . . . my water broke in the morning so I called him at work and it was a lot, like promises, like "Oh wait, I'll come on my lunch hour." So I had to wait until twelve. He came for his lunch hour, dropped me off at the hospital, went back to work at one o'clock. . . . And then after five he couldn't come after work, you know, he had to go home, have a shower, cook, have supper, you know, like he can't miss a beat. That wasn't important enough (Deb, 924-934 A).

Deb and Beth described their partners' involvement as visiting:

> He comes, you know, to visit. That's what it is. He comes to visit (936-937 A). . . . At the time I was in the delivery I was very, very upset because he wasn't, he didn't want to stay and he wasn't there most of the time. I was there for twenty-four hours, he would have stayed maybe three hours of the whole thing (847-851 B). . . . He didn't want to go in the delivery room. And I begged him. I don't know what changed his mind but I started threatening him and so that, "If you don't come I'll never talk to you again. I'll tell my parents" (Deb, 988-992 A).

> He never even took off work, he just came when he was finished work and he maybe stayed for about a half an hour, that's it (930-932 A). . . . He was never in the room with me. I had (daughter) alone (Beth, 251-252 A).

Some of the women described their partners' presence as an additional stress to them while they were in labor and did not want them present. They feared being reprimanded if they had difficulty coping or made noise:

> I didn't want him there anyway because if I would have freaked out or had pain or whatever, God knows what. I didn't need any more stress on me than I was going to have birthing. I would have rather done it alone, so that's what I did (Beth, 504-508 B).

> When I was pregnant with my daughter, I was afraid though to have him there because I was afraid he would tell me I was a wimp and that it wasn't all that painful. And I was really scared (Ellen, 202-205 A).

> What I wanted was to feel like a closeness and there isn't, you know. It's fear. It's, I better not make any noise because he gets embarrassed (971- 974 A). . . . He was mad at me. I had so much back labor and (baby) was turned wrong. And he was just totally unsupportive. It was just something I had gotten used to, I suppose (Fay, 382-385 A).

Although Amy was no longer with her partner, she agreed to call him when she went into labor. He was not supportive to her during the labor and delivery process:

> We were split up when I went into labor, like he wasn't living with me. He insisted that I call him because he wanted to be there. So I did. . . . So I phoned him and woke him up at a friend's place and he called me a liar (275-281 A). . . . He says, "If you're not in labor, I'm going to be pissed right off." And just berating me and I just ignored him. We got into the (hospital) . . . and he proceeded to pull up on the Easy Boy (chair) and go to sleep and he slept through the whole thing. . . . I'm on my hands and knees curled up in this bed and I'm freaking, I couldn't believe how much it hurt and he's reeking like dope and alcohol (313-332 A).

Two of the women were surprised by their partners' supportive manner. However, the abuse continued and escalated in severity after the baby was born. Carla's partner provided support but never forgave her for swearing at and hitting him when she was in labor:

> He was present for the labor. He was actually not too bad during labor . . . he was you know, "Breathe. Hold my hand. Squeeze my hand." Whatever. And I did actually hit him in the face. I actually punched him. . . . I didn't even know I did it but I guess I did and I told him to "F-off" and all this other stuff and he took that very offensively. . . . I had no recollection of doing it but he remembered it right even till the time we broke up. That was one

> thing he would never forgive me for was hitting him and swearing at him and stuff while I was in labor (628-639 A).

The abusers' lack of involvement and support often extended into the postpartum period, exhibited by minimal parenting roles:

> He never gave her a bath, never changed a diaper, you know. Like even with clothes, he never bought clothes or anything like that. And he wouldn't buy a stroller (Deb, 1123-1126 A).

> He didn't really have much to do with them (children). Because we had gone through a lot of stress, I had toxemia, she was premature. He didn't have nothing to do with her for six months. He wouldn't even hold her. He'd come to the hospital, she was in there for twenty days and he wouldn't go visit her (Gina, 119-124 A).

In summary, pregnancy was an unplanned and often unwanted event. A common reaction of the women was denial and a desire for the pregnancy to be terminated. The abusive situation and their partners' reaction to the pregnancy greatly influenced the women's responses and subsequent decisions. The men attempted to exert control over either the termination or the maintenance of the pregnancy. Most of the women experienced an escalation in abuse as a result of the pregnancy. It was common for the abusers to provide minimal support to the women. Abuse occurred during the antepartum, intrapartum, and postpartum periods.

Effects of Abuse on Women's Health

The women experienced various effects on their physical and emotional well-being which were either directly or indirectly related to their abusive relationships. Most of the women experienced some form of chronic health problem. All the women indicated that they felt stressed and that this was often accompanied by anxiety and panic attacks. They also all reported that they had low levels of self esteem. Five of the women reported having bouts of depression and suicidal thoughts. Often the women's health state was further jeopardized by a tendency to not take care of themselves. There is evidence that the abuse did have an effect on the pregnancy as all of the women experienced some form of complication. Reported complications included infections, hemorrhage, abruptio placenta, preterm deliveries, low birth weight infants, and stillbirth.

The Effects of Stress on the Womens' Health

All of the women reported high levels of stress which they generally related to other health problems. In the following excerpt, Gina describes how she saw the stress affecting her health: "I was under a lot of stress. . . . I was in the hospital one night. My blood pressure was so high they had to give me nitro. That's how much stress I was under" (1269-1273 A).

For some women the stress manifested itself in anxiety and panic attacks, and sometimes pregnancy could interfere with the treatment of the woman's condition:

> I ended up having anxiety attacks. I was on antidepressants when I got pregnant with (daughter) . . . and what ended up happening was I had to get off them because I was pregnant (Beth, 142-146 A).

Deb believed her high level of anxiety contributed to the severity of her nausea and vomiting during pregnancy:

> At the time of my pregnancy . . . I know that the anxiety probably increased, like I was nauseous like every pregnant woman but because of the anxiety and stress around it . . . everything became ten times worse. . . . I was physically ill, like I would throw up. I lost so much weight (457-462 B).

Fay indicated that living in constant fear had a detrimental effect on her health: "Oh God, I was not doing well. Scared all the time" (849-850 A). Ellen believed her fear led to actual panic attacks:

> When I was pregnant the last time I got afraid a lot. When I was pregnant I would be afraid to answer the door or I was afraid to go places. . . . A lot of times at night I didn't sleep because I was afraid. I was waiting for him to call. And sometimes I think I might of had a panic attack (982-993 B).

Low Self-Esteem

All of the women described themselves as having low self esteem. Many of the women knew they had low levels of self esteem prior to the abusive relationship and that the abuse they experienced increased their feelings of worthlessness: "My emotional health was definitely negatively affected. . . . I was in bad shape emotionally. I had no self esteem" (Amy, 612-613 B).

Depression

Another common health problem associated with abuse was depression. The women reported feelings of depression and three of the women received treatment for their depression. Beth saw herself as severely depressed: "Depression. Mega depression. I didn't even want to take care of my children. I didn't want nothing. I didn't want anybody coming near me, anybody coming around me" (1079-1081 A). She eventually became withdrawn and would take measures to avoid others:

> For two months, anxiety attacks everyday, every time I would go out. I would literally hide in the bathroom when somebody came, you know. They'd see my car outside, knock on the door, and me and the kids would be in the bathroom so they wouldn't make any noise (1113-1118 A).

As a result of the abuse, Beth became emotionally deadened: "I had no feelings left whatsoever" (211 A). Fay coped with the abuse by emotionally tuning out what was happening so she would not have to feel it: "The verbal abuse was so constant that I just had pretty much shut down all over" (866-867 A).

Amy describes the feelings of loneliness, worthlessness, and self-blame she experienced postpartum. She did not receive treatment for her depressive state:

> I suffered quite serious postpartum depression after I had my baby. . . . I was alone in a crowded room, you know, I was lonely when there were people around. I felt worthless and that I deserved everything I got and that, you know, it's my own fault that I was with this guy (1238-1257 A).

Suicidal Tendencies

Some of the women reached a level of hopelessness that was manifested by thoughts of suicide: "I wished I was dead. Anything is better than this" (Beth, 666-667 A). Fay talked of the period when she considered taking her own life and the life of her children because it seemed like the best solution to her situation:

> I used to pray every night . . . I just wanted to die. Just let me die. I was suicidal. . . . Never thought I'd think that. . . . I can remember thinking to myself, I'm alone with these children. These children don't have a safe place to go either. . . . I hate to admit it but I honestly believed that they would be better off if I just drove off the (bridge) with them. That was a better chance than anything else (1067-1184 A).

Deb also felt like dying but did not attempt to commit suicide because she had a daughter who needed her: "I felt like giving up and just dying . . . but I have a kid and I think that pulled me through a whole lot" (443-445 B).

In contrast, when Amy feared that her partner would kill her, she informed her physician and friends that she would never commit suicide:

> I'd go to the doctor, I'd show him my injuries and say, "Keep this on record. In case anything happened." I'd go to my friends and I'd say, "If anything ever happens to me . . . don't look at it like a suicide. I would never kill myself. Never. Don't think it was an accident. Make sure you investigate everything." I told several people this (1141-1148 A).

In summary, all of the women reported emotional and psychological health problems which they believed to be attributed to the abusive situations in which they lived. The abuse endured by the women left them questioning their self worth and the value of living.

Complications with Pregnancy

The women also believed that the abuse they suffered and the subsequent stress contributed to complications that they experienced during their pregnancy. Carla, Fay, and Gina were all victims of physical abuse during pregnancy which they believed directly affected their pregnancy and the unborn child.

In Carla's case, her boyfriend would not allow her the rest she required to recuperate from surgery. She developed a post-operative infection in her cesarean section incision: "After (son) was born I never got a chance to settle at home with him. . . . So my incision obviously got infected because I was never home. He would never let me stay home by myself" (667-678 A).

Fay experienced frequent episodes of antepartum bleeding during her pregnancies. She was hospitalized for abruptio placenta following an episode of violent intercourse. Fay received no support from her husband during her hospitalization, in fact, she believed her husband blamed her for inconveniencing him:

> At seven months I had an abruption and I was in intensive care for a week and (daughter), she suffered minor brain damage as a result. And he did not want to come and visit me. And he was just really angry, you know. I mean, this was an inconvenience for him because now he had to find somebody to look after (son), who was little. He hated the fact that, it was like I was a wimp, like he just hated it. I never saw any compassion, you know, and like to be in intensive care, it is pretty frightening (200-209 A).

Gina sought medical treatment for sudden, severe abdominal pain. When she was asked by the physician about recent injuries she denied the fact that her partner had beaten her. She was diagnosed with abruptio placenta which resulted in the stillbirth of her daughter:

> She (doctor) took the ultrasound and she found, she said a blood clot first. And she asked me if I had an accident in the last two months, if I had fallen or anything, injury. I remember looking at her and denial, denial. I said "No". I said "No". And that was hard (966-971 A).

In a previous pregnancy Gina experienced complications of high blood pressure and intra-uterine growth retardation which resulted in a premature delivery by cesarean section. She attributed this to the stress she was experiencing in her abusive relationship:

> They had taken her five weeks early. But before that she hadn't grown for five weeks. She had stopped growing. So she was tiny, she was three (pounds) seven (ounces) when she was born, because I had toxemia. . . . He (doctor) said I could of had a stroke and the baby could of died. So I had an emergency C-section right away (155-169 A).

Sexually Transmitted Diseases

All of the women either suspected or were aware of their abusers' sexually promiscuous behavior outside of the relationship. Amy contracted sexually transmitted diseases (STD's) as a result of her partner's unfaithfulness. She was pregnant at the time of diagnosis, which altered the treatment she was able to receive:

> He gave me venereal disease. Three or four different types of venereal disease, trichomonas, mycoplasma, ureaplasma, gardnerella, all at once. . . . They couldn't treat them because I was pregnant. I could only use this cream. I needed pills too and I couldn't take the pills (228-233 A).

Urinary Tract Infections

Deb and Ellen both experienced urinary tract infections in pregnancy. During later reflections, they both believe that the abuse related stress they suffered had made them more prone to contracting infections. Deb's problem was chronic bladder infections. Her doctor treated the physical symptoms but the psycho social connection to the stress she was experiencing was not made until she was seen by a nurse at a women's shelter. Her own general practitioner did not associate the bladder infections with her history of abuse:

> But she (doctor) still has never associated the bladder infections. And she has associated the anxiety and depression together. And it is only until I talked to that nurse at WINGS that she said, "You know, a lot of women who suffer from a lot of anxiety because of the situation they are living in, they have constant bladder infections and you just strain a lot. A lot of stress puts a lot of strain on your urinary tract system" (406-413 B).

Ellen was hospitalized during pregnancy for kidney infections. Her husband was not supportive during her illnesses and was reluctant to take her for medical treatment: "I was in hospital a few times because I had kidney infections with my son. He never was willing to take me to the hospital" (190-192 A).

Poor Weight Gain/Small for Gestational Age

Three of the women had poor weight gain with their pregnancies. All of Ellen's children were small for gestational age:

> Except for stress I was healthy. My doctor was really concerned because I would have died, like I was really sick. When I had him I weighed one hundred twenty-six pounds and I'm five (feet) five (inches). So he was kind of concerned about that (695-698 B).

Decreased Self Care

The women described a tendency to not take care of themselves and in some instances this seemed to be related to their low self esteem. To cope with the situation some abused women turn to drugs and alcohol, as Fay explains:

> We have a tendency not to take very good care of ourselves. Like we don't think much of ourselves, you know. And we know the baby needs but . . . those things won't connect in our brains all the time. When our self-esteem is so low, it's not. Often they're eating too much I would say, or not enough. I know that's where a lot of alcoholism and drug addiction is coming in for women (697-704 B).

> But at the time I didn't know why I was doing all this stuff, like going out and getting drunk and all this stuff. See, when I see a woman pregnant in the bar, the first thing I want to say to her is, "Don't do this." But I don't know what kind of situation she's in, why she is doing that. Nobody wants to have a fetal alcohol syndrome child. But if you are in a relationship where that is your only option, to get drunk and forget about it for a while, you know, what can you say to this woman to not go crazy, right? What can you say to this woman? You know you can't turn around and say, "Well, don't do this." If that is the only way that she is remaining sane (Beth, 863-874 A).

Fay further explains how she was reluctant to seek medical attention for her ailments:

> You don't sleep. I was always so worried about being a hypochondriac that I wouldn't have medical problems addressed, like I wouldn't have them attended to. I wouldn't do it. I also believed that because I smoked I didn't deserve to have medical attention. He used to tell me that I was a pig because I smoked. Well, he smoked too (882-888 A).

In addition to low self esteem, Beth also indicated that because the pregnancies were unwanted she was not motivated to take care of herself:

> You get sick a lot more. You don't eat right. You don't want to eat. And you don't eat right. You eat a lot of junk food and stuff like that because, "I'm fat anyway, what the hell?" You know, I don't think you even want to take care of yourself and you want the child to die (1369-1373 A).

All of the women reported detrimental effects of the abusive situation on their physical and emotional well being. The stress associated with the abuse led to low self esteem, anxiety, depression, suicidal tendencies, as well as chronic and acute physical ailments. The women believed the abuse had a direct effect on their health during pregnancy and in some cases, a direct effect on fetal well being.

Interactions with Professionals

The women had a variety of experiences and interactions with professionals during the course of their abusive relationships. The major classifications of professionals included: (a) nursing, (b) medical, (c) social services, (d) legal services, and (e) community services. The women had both positive and negative experiences with professionals in all of the categories.

Nursing

Several women had positive experiences and interactions with nurses. The attributes of nurses viewed positively by the women were gentle, caring, non-judgmental, and understanding. Nurses who intervened appropriately, took actions to protect the women, provided advice or information, and acted as an advocate for the women were considered to be helpful.

Amy described the nurse's kind and understanding manner that helped her cope with the labor and delivery process. She believed the nurse understood her abusive situation and responded by providing support and encouragement:

> She was so kind and just really understanding, she knew what I was feeling because of (partner). She knew what was going on. I mean she'd been there for hours and she just told me, "Don't worry. It'll be fine. You'll get through this" (500-503 A).

Amy also described the nurse as acting as an advocate for her by promising to contact her physician and doing so: "She did what she said she was going to do and that's what I appreciated about her" (513-515 A).

Beth appreciated the advice she received from her community health nurse. Because Beth was not ready to leave the relationship, the suggestions were directed toward Beth finding an outlet by which she could focus on herself and obtain a sense of purposefulness:

> She told me to get a job, or to make myself happier, like get a hobby, go out more, stuff like this she was telling me. Um, to make myself happier, to be satisfied with myself. . . . You know, to go out and do something with my life. Like either go back to school or something. . . . I think that's the way to go because if you get a job, you're going to be more independent or else if you get a hobby so you can tune him out (564-581 B).

Carla described the supportive manner of the nurses when she was hospitalized after an abusive episode. She believed she received individualized care which reflected an understanding of her physical and emotional needs:

> After being physically abused, they don't suggest that you get out of bed, right? But when I went down for a cigarette, the nurses didn't say anything, you know. . . . Because I was in a lot of pain, so they prescribed a pain medicine for me. They said, "When you get back you can go for a shower, then we'll give you some medication for the pain." And then they didn't hassle me about it. They were really nice. They said, "If you want to talk we're here. If you just want a shoulder to cry on, we're here. Just kind of take it easy." They were very, very supportive (422-433 A).

Ellen was registered under a different name when she was hospitalized for the birth of her child. She considered the efforts taken by the nurses to protect her identity as necessary during a time when she was very vulnerable:

> The nurses registered me under a different name so that he couldn't come. His cousin phoned and said that he was the brother of my husband so of course they knew that something was up and they wouldn't let him through (522-526 B).

Although measures were taken by the hospital to protect Ellen's identity, some of the nurses did not follow the procedures. As a result, Ellen was put in an unsafe situation by a call to her room informing her that her abusive partner was there to see her. The nurse's error in judgment placed Ellen in the position of facing her partner when she was very vulnerable:

> I think he shouldn't of even been able to get to the floor. He shouldn't of been able to. . . . I think because there was supposed to be security I think the nurse should have said right away, "Sorry there's nobody here by that name." I don't think she should have paged my room because then he knew I was there. She pages my room while he was standing there and said, "There's someone here named (partner). He wants to see you." I think that should not have ever been done. And so I said, "Okay." Like what am I, I mean it was a really bad time. . . . I shouldn't of even had to have known that he was there (899-913 B).

Ellen returned to the hospital in the hopes of obtaining a statement from the nurse who was working the evening her partner came to the hospital. She was disappointed by the nurse's claim that she did not remember her or the situation. As a result of her experience, Ellen recommended documentation by staff of situations where abuse is involved for the purpose of assisting the women with legal proceedings in the future:

> I went back because I knew which one it was, she says, "Well I don't remember. There's lots of people, that happens to lots of people. Lots of guys come back in." And well I said, "Lots of people come in on Christmas Eve and cause things like that? (Specific ethnic) people?" She goes, "You'd be surprised how many." So she didn't remember us she said. So I think, in actuality, I think when things like that happen there should be some kind of book or something and dates and names should be recorded. . . . So that if somebody does need it, it's there. . . . I thought maybe I could get a statement from her saying what happened and she said, "I don't remember. It happens too many times" (930-950 B).

Other women also had negative interactions and experiences with nurses. There were times when the women's stories were not believed and the nurses passed judgment on the women on the basis of their situation. In addition, there were instances when the nurses were reluctant to intervene or get involved in the situation. Amy described how she wished one of the health care professionals had intervened by asking her partner to leave the labor room. While she was in labor, Amy did not feel capable of acting on her own behalf. During this period of time Amy needed an advocate, which unfortunately she did not have:

> At that point I wished somebody would have intervened and said, "Why don't you step outside and let her calm down, you're obviously upsetting her." Nobody did that. They were afraid of him. I mean, this big hairy, greasy biker, obviously smelling like alcohol and drugs. I mean, you people aren't stupid. You knew what he was up to. Nobody appreciated him in there. I don't know why anybody didn't say anything. Obviously I couldn't. I probably should have told him to get out, but I was just so delirious (404-430 A).

Amy felt judged by the health care professionals because of her partner's behavior and demeanor. The situation made it more difficult for her to cope with the labor process:

> I was totally embarrassed and mortified. Like they're looking at him, like, "Oh what a goof. . . . What a slob. What are you doing with him lady?. . . What's wrong with you?" You know, that's the feeling I got from them was that they were looking down on me because of him. And that may have had something to do with why I was having so much pain and wasn't able to deal with it (341-348 A).

Amy talked about the time when she was approached by a nurse on the postpartum unit as she was being discharged from the hospital. She was shocked by the nurse asking her if she was being abused. For Amy, the inquiry came too late. Perhaps if she had been approached earlier in her hospital stay, Amy would have been able to access the resources offered:

> And then as he was leaving, walking down the hall, the nurse came up to me and said, "Is he abusing you?" And I just looked at her and my eyes sort of bulged out, like, how do you know? Right? And she says, "If you have any trouble you call the hospital and somebody here can direct you to the right place." And she said, "You don't have to go home. If you don't want to go home, you don't have to go home." And I was just stunned that somebody had said something to me. And so basically I was in shock, that I started to cry and I took off out of there, you know. That she had just come and approached me as I'm leaving. Like I wished somebody had said something sooner. It was too late at this point. I was already on my way out of the hospital and I was going home (571-601 A).

Amy described feeling judged by the nursing staff when she was admitted to the hospital for dilation and curettage following a therapeutic abortion:

> I was treated like shit . . . because they knew I was there because of a failed abortion. It was like they looked down on me. . . . They all knew why I was there and then they looked at me like I was dirt. You know, "What's your problem? Why don't you use birth control?" I did use birth control. That's the feeling I got (850-910 A).

During Amy's labor process she experienced a feeling of powerlessness during which she wished one of the health care professionals present would have intervened on her behalf: "There's nurses in there, there's a student intern in there. They saw what he did to me. They saw that he was physically holding this thing (the mask for analgesia) on my face. Nobody did anything. Nothing" (391-397 A).

Based on her experiences, Amy shared thoughts about characteristics which she felt were important for a therapeutic patient/nurse relationship. To Amy, being non judgmental is one essential attribute of an effective nurse:

> If you can spread the word around to other nursing staff, because they don't know people's situations. They don't know what a woman has been through or why she's come to her decision. And their own personal feelings should never come into a patient/nurse relationship. I don't think their personal feelings should come in there. I think they should show compassion, no matter what they feel. You know, no matter who the person is or what they have done. Because like I said, you don't know that person's situation and unless you're ready to sit down and talk with them about it and try to understand, you shouldn't pass judgment. You can make matters worse by doing that. People don't seem to realize, some people, you know. I'm not saying you're supposed to be a saint or anything because you're a nurse, but generally speaking, if someone goes into nursing or medicine, you know, it's because they want to help people and not make them worse. So their behavior and their reactions should reflect that (415-444 B).

Ellen also expressed feelings of vulnerability during the labor and delivery process. She was concerned for the well being of her baby and afraid of her partner's reaction to how she coped with the birth process. Ellen described how the nurse's expressed opinion of the size of her baby caused her to be concerned about the well-being of her baby during her labor process:

> And the nurses, the reason why they made me cry is because this nurse kept telling me, "Your baby is going to be between four or five pounds, five pounds at the most. It's going to be really small.". . . And the doctor said, "Don't listen to them. It's going to be six pounds." You know, he was really, really good. Like, he knew that I was upset and concerned and that was really good. Well the nurse kept making me feel like, oh no, something is going to be wrong with my baby when he's born (800-815 B).

Gina described the lack of assistance she received from a hospital employed nurse that she spoke to on the telephone. The nurse did not investigate Gina's situation further or provide information about additional resources. After receiving no assistance, Gina returned to the abusive situation:

> I phoned one of the nurses up at the hospital one night. I was trying, I was talking to her about, you know, at home I wasn't feeling good. I was asking if proper nutrition is milk and stuff like that. And she more or less told me, "Well you know, you can live without milk. You don't need milk. It's not going to hurt you to not have milk for a couple of weeks.". . . I was really upset about that. . . . I wasn't even home. I had walked to the phone booth because I wasn't allowed to use the phone. He took the phone right out of the wall. . . . I don't even know why I was bothering asking her about nutrition and stuff, because that, you know, that wasn't the real problem. But I did tell her that we were having an argument, you know, and I had no place to go. You know, I

> haven't been eating right. And she couldn't help me with that. So I hung up the phone. I went back to the house (756-777 A).

It is essential for helping professionals to listen for the hidden message in the women's words. As demonstrated in Gina's example, if subtle cues are missed the woman who may have disclosed and accessed resources is more likely to return to the abusive situation.

Fay shared that one of the most important aspects of nursing care is to listen to the woman:

> For nurses just to be kind. I think that's it. You know, just to show that compassion. Like if someone is telling you something, if someone is disclosing, the best thing to do is to shut up and just listen. And I don't mean to sound coarse but when a woman starts to say, "I feel . . .", oh boy, just let her go. Because most of us haven't said, "I feel." You know, it's amazing what that small effort, what a big step it can make for a woman and the children, is to say, "I feel scared" (717-725 B).

Both Amy and Ellen talked about wanting to stay in the hospital for a longer period of time. Amy was discharged and did not feel she could stay longer than the designated period of time: "I was there for two nights. I wanted to stay. They wanted me to leave, but I didn't want to go for obvious reasons" (547-549 A). Although Ellen did not want to leave the hospital, she no longer felt safe staying once her abusive partner knew she was there: "We shouldn't of left the hospital. We left too soon. But I was afraid to stay there" (574-575 B).

Medical

The women had a wide variety of positive and negative experiences with physicians. Five of the women eventually reached a level of trust with their physicians at which they disclosed the abuse. The women described these physicians as gentle, "in tune" with the issues related to abuse, and committed to stopping the cycle of abuse. Supportive measures by physicians included emotional support, referrals to resources, and the provision of specific advice on how to leave the relationship. As well, some physicians provided documentation and testimony for legal proceedings.

However, some of the women also had negative experiences and interactions with physicians. Some physicians did not have a manner which was conducive to the women disclosing. Some physicians failed to adequately assess or further investigate the women's situations. Other physicians were reluctant to become involved in the women's abusive situations. The women's positive and negative experiences with physicians will be discussed within the categories of relationship with physician, assessment, and intervention.

Relationship with Physician

The relationship with the physician was identified as an important factor in the woman's experience. The physician's manner toward the woman was the key to whether she trusted enough to disclose. Ellen had a close, long term relationship with her physician and had confided in him about her relationship problems:

> My doctor was really, really good for me. Well, my family doctor knew a lot. He had known, I told him everything. I told him when (partner) thought I was cheating on him. I told him, I went to see him when (partner) had physically assaulted me. And so he wrote a letter. . . . It was a letter about me. About how I had been seeing him for ten years and the situation I was in, and it was a really wonderful letter. It was like, you know, she needs extra care (706-715 B).

Ellen perceived the relationship with her physician as a partnership in which she was included in the decision making process for aspects of her care: "He was much more calm and gentle and he never told me, 'We're doing this.' But always asked me" (741-743 B).

Carla received emotional and instrumental support from her physicians. Referrals were made to community resources to assist Carla with her situation:

> They're always there. Like if I need to talk to either one of them, they're always there. You know, because of all the physical abuse and stuff that I've gone through they've scheduled a C-section for this baby so I don't have to go through all the labor and stuff, which helps a lot. They've assigned a social worker from (agency) for (son). Child welfare is involved because of what has happened to him. They've done a lot. They've set up a lot for me. "Go to WIN House." They said, "You don't have to necessarily charge him." But they advised me to go to WIN House (385-399 A).

Fay also received emotional and instrumental support from her physician. Eventually, she felt comfortable disclosing to him and felt safe because he ensured her of his support:

> I thought he (physician) was wonderful. He just, well he just kept saying, "I'll get you out of there. I'll do anything." Because I was telling him, "(Husband) is going to kill me. (Husband) keeps saying he's going to kill me. He's going to take the kids." And (physician) said, "Well, we're not going to let that happen" (649-653 A).

Assessment

Fay's physician had insight into the dynamics of abusive relationships and effectively provided care and support to her during the period of time that she was unable to disclose. His demonstrated understanding and compassion, which enabled her to turn to him for assistance, helped her to cope with the situation:

> He (physician) says, "You cannot carry this load any more." And he knew what it was. And he was angry. But I think he also had a good enough understanding that, he was somebody that had the insight. Like if I wasn't ready to disclose and if I disclosed it could mean I could get killed. Anyway, (physician) very gently helped me and kept me together through those times. . . . He had the insight to see that, you know, something was wrong, what my problems were. . . . I could talk to him and talk to him, and that's important (1169-1186 A).

Deb's general practitioner inquired about the dynamics of her marital relationship, but Deb did not recognize her experience as abuse. As a result, the connection between her anxiety, depression, and abuse was not made:

> She (physician) knew that I had problems, but she thought you know, at least she never mentioned that it is connected with this, anxiety symptoms or depression symptoms. Like because she asked me like, "How is your marriage?" And so on, and I told her that we don't really, we kind of lead separate lives. You know, and I didn't understand. I think I didn't know how to explain to her either. And because she asked you know, "Does he beat you?" I said, "No." "Does he insult you or anything?" I said, "No" (321-337 B).

Some of the women felt there were clues that would have been indicators for further assessment to health care professionals knowledgeable about abuse. Ellen's physician wanted her to be hospitalized for threatened premature labor but her husband would not allow her to be admitted. In hindsight, she thought her partner's lack of concern for the well-being of her and the baby would have been a clue to be further investigated by the health care professionals:

> They (physicians) told him that they wanted to keep me over night because the contractions were irregular but they wanted to observe me. And he said, "No." I had to come and take care of the baby. I couldn't stay there (457-460 A).

Because Deb was not knowledgeable about the various forms of abuse she was dependent upon health care professionals to detect the subtle clues of her situation:

> I would have told him (obstetrician) just as much as I knew at that time. You know, I would explain to him, "Well, he doesn't really want to go, he usually doesn't go and he really ignores me a lot. This is not his problem." Stuff like that, that would, somebody who is in tune with abuse would pick that up but most normal people wouldn't. So, I think you really have to be in tune with knowing those subtle things. And maybe it's just an intuition or a feeling for the doctor to think, "Well, you know, maybe this is not right" (512-520 B).

In hindsight, Deb felt her obstetrician should have assessed her situation further by inquiring about her husband because he was never present for any of the office visits. Deb believed her husband's absence may have been a clue to someone who had knowledge of abuse:

> One thing when I think about it in hindsight, he could of asked me more about the relationship with my husband. Because my husband never came to the visits. He never saw him, you know. He never met him at the delivery, so he must have wondered, you know, like what is this? What kind of relationship? So somehow, but he's a man, so I don't know. He was very kind but now in hindsight I wished, like there were clues from him, but he didn't seem to see anything wrong, or anything different (482-490 B).

In contrast, Gina's partner was present at all of her physician appointments. Because of his presence, Gina could not disclose. Gina also did not feel comfortable telling her physician about the abuse because she feared he would judge her and she would not receive as high a quality of care:

> The doctor that I was seeing on my prenatal visits, once a month, he had no idea. You know, I didn't tell him. Pretty much, simple fact, my partner was with me every visit. I had to go with him. He had to come with me all the time. I couldn't go in the office alone. And that I was too scared to tell him. If I told him then I wouldn't get the quality care, I wouldn't get, I don't know. I think he'd be labeling me or something like that. You know, I think I wouldn't of got that much care if I told him. That's what I think, that's just the way I feel with my doctor. Because I've known him for so many years. You know, it's like, he knows me but he can't know that part of me, you know. It's like a front. I've been putting up a front. You know, if he found out, you know, I'd be scared what his reaction would be. So I didn't tell him (298-319 B).

Gina's behavior may be indicative of low self esteem. She felt ashamed about her situation and feared her true self would not be accepted. A lack of trust in the patient-physician relationship hinders the possibility of the woman disclosing about her situation.

Carla's obstetrician and pediatrician both knew her partner from visits to the office but did not suspect him as being abusive. He was able to deceive the physicians by his public persona as a loving partner to Carla:

> He (physician) was actually quite surprised. He knew (partner). Because I'd go to the doctor for checkups and he's my obstetrician, so I'd go for pap tests or whatever the case may be and (partner) knew my doctor because he would come with me. And he knew (son's) pediatrician because he'd come with me. So they both knew him so they were actually both quite surprised and actually quite perturbed because they didn't think (partner) was the type. . . . Because when we're around them he'd treat me really nice and sweet and all lovey dovey (367-377 A).

At times the assessment process was complicated by the women's attempts to conceal the abuse. "He broke my thumb. . . . I remember telling the doctor that I dropped a coffee table on it when I was moving it" (Ellen, 853-855 A). Other times, the women would not disclose because they did not believe the health care professional cared about them. A caring manner was identified as essential to the development of trust. Fay would not disclose to an emergency room physician because of his indifferent manner: "I wouldn't answer him. I just, I wouldn't answer. I refused to answer him. But then he didn't have the manner. I didn't trust him. He didn't give a damn and I knew it" (632-635 B).

Gina went to the hospital following an abusive episode and was assessed for signs for physical injury. However, she did not receive any assessment or monitoring of fetal well-being. She was later admitted with abruptio placenta which resulted in the stillbirth of her daughter:

> I had to wait a while for the doctor and they just checked me out. You know, they didn't see anything, um, physical with me with the fall. There's nothing they could detect, you know. They didn't do any ultrasounds or anything, or monitoring of any kind, it was just, lay there for a half hour (801-806 A).

Intervention

The women received varying degrees of intervention from physicians. Forms of intervention ranged from no intervention to interventions such as advice, support, referrals, and medication. Deb's physician became her main support and was willing to provide documentation and testimony on her behalf:

> When I did go to a shelter and so on and I needed her to sign letters for Social Services and so on. She was always very cooperative and very encouraging. And she really, really became my main support. And she said, "If you have to go to court and need somebody to testify about your condition . . ." Because I told her he threatened me with this condition that I am supposed to have. And she says, "Oh, that's totally crap. Like that doesn't wash and I will go anytime and testify for you in court. That actually proves that you have more sense than him because you actually looked for help." So she was very strong about it all the time (388-399 B).

Beth disclosed to her physician about her abusive relationship, however she declined her physician's offer to speak to her husband because she feared violent retaliation:

> He (physician) kept wondering why I was having so many anxiety attacks. And then I told him, "This is my situation at home. This is why I know I am having these anxiety attacks." He said, "Oh, that's not good (Beth). Blah, blah, blah, blah. Do you want me to talk to him?" And I said, "No, I don't want you to talk to him." I can just imagine what that would have done. But it was just mostly ignored (842-848 A).

Amy's physician was aware of the relationship problems and stated her opinion, but did not provide Amy with emotional support or specific advice on resources that could assist her to leave the relationship:

> She (obstetrician) just told me she didn't like him and there were lots of single parents out there. I could do it on my own, she knew that. And that was really the only thing she said to me. She's a really good obstetrician but she doesn't have much of a bedside manner. She's sort of like in and out. Rushes you through like cattle. . . . She knew that there was stuff going on. . . . She asked me, you know, "What are you doing with him?" And, "Do you realize you're putting your baby at risk?" What she had said to me was, "When he abuses you, he abuses your baby" (1164-1183 A).

Many of the women talked about the feelings of confusion and lack of awareness of what was occurring in their abusive relationships. For Amy, being told simply that she should leave the relationship or go to WIN House was not enough assistance. At the time, Amy required counseling to help her to understand the situation and assist her in the decision making process: "One suggested I go to WIN House, that was it. . . . But no other advice or just, 'You should leave'" (185-189 B).

In contrast, Deb's general practitioner was careful not to tell her to leave her husband but did indicate that her home situation exacerbated Deb's conditions of anxiety and depression:

> She never recognized it as abuse. She just knew, she said, "You know, you have to make a decision sooner or later what to do about it, but you can't go on living like that." She told me that but she would be very, very careful not to encourage me to leave my husband. She never said that. You know, she just said, "It has to be, you probably have some inclination to get depressed,

> like chemically." But she says, "Your home situation makes it ten times worse." So she did associate that (379-388 B).

Deb's general practitioner prescribed medication to treat her anxiety and depression. In hindsight, Deb feels she should have received counseling in addition to the medication to assist her in understanding the cause of her emotional turmoil:

> She (physician) always says, "Well you know what the cure is and we have the medication. We know it works really well on you. You're lucky about that, so why would you suffer?" Because I always want to toughen it out. I don't want to be on medication. I am better than that. I should just snap out of it and I have such a hard time with that. I think also is I never got counseling to go with it, it was just the medication. So I never understood where it came from and so on. I'd still never associated it with a bad marriage (302-315 B).

Fay encountered several physicians who did not become involved or provide support to her and her children. At times the abuse was minimized by the health care providers. This response caused Fay to distrust health care professionals. She expresses her anger and frustration in the following passage:

> I would check any of the professionals out, can I trust them or not? No, there wasn't a one I could except for (physician). That's only because he had the courage to press the point and promise, and did. And same with (physician), stayed with me on it. Where they said that, yes they would go and testify. They would because they've seen it and they're not in any denial about it. They know that telling the truth is what's going to save these kids and there's only one way to break the cycle. For all of us, not just one family, but for all families that are enduring this. It's not enduring it, living it and perpetuating it. I felt really angry with doctors that have just sort of, you know, "Big deal. So he smacked you" (611-623 B).

Gina lost faith in the helping professionals after repeated attempts to obtain assistance from nursing, medical, legal, and social services. As a result she stopped asking for assistance which she now has feelings of guilt about:

> Sometimes I get mad at myself because I had a mouth. I could of said something, you know. It's like, I could of said, "I don't want to go home." You know. I was scared because of the past experiences. Everywhere I went the doors were closing, you know. I thought they probably wouldn't help me, couldn't help me (269-271 B).

Social Services

Some of the women accessed the department of social services for assistance, however not all of their interactions were viewed positively. Amy described undergoing a humiliating investigation by social services when she was feeling alone and vulnerable:

> I was very alone. . . . And every time he showed up you know, it was a fight or something. You know. I was broke, I had no money. Somebody called Social Services and said that I was living with him and I wasn't. He had his own place. So they held my cheque back and investigated me for fraud and they literally came through my house. You know, I was just attacked from all ends (1306-1317 A).

Gina contacted a social worker to ask for assistance when she did not have enough food. She also informed the social worker that she was afraid of her partner. Gina was disheartened by the social worker's response because once again her partner was believed instead of her. As a result Gina lost faith in obtaining any assistance from the social services department:

> I'd talked to a social worker, as well, about you know, not having enough food. We weren't on social assistance but I phoned up, you know, seeing if they could help us or help, you know, myself. And my ex called her up because he found out I went to see her and he gave her, I don't know, he talked to her for an hour and gave her this story. I don't know what he said about me, but I asked, you know, I asked her for help. . . . I told her I had to leave. And she said she couldn't give me any money to leave. She said, "But you know, your ex, he'll give you money in the morning for a bus ticket." And I told her that day, I said, you know, "I don't know, I can't, you know. I'm scared of him.". . . I just lost faith. I lost hope in any kind of social services or anything (841-862 A).

Gina also described a very positive experience she had with a social worker while she was hospitalized. The interaction was particularly positive for Gina because her story was finally believed and her experiences of abuse were validated:

> In the hospital though there was a social worker who was excellent. She spoke with him because he went to talk to her. Because I was, at that point I'd had it, you know, because he was abusing me physically in the hospital, you know, so I had to talk to somebody. I talked to the social worker in the hospital. For once somebody believed me. For once. You know, she said she met with my ex for an hour and she said she saw right through him. To me that was, oh thank God. You know, finally (1098-1107 A).

Deb was never referred to social services but she wondered if she would have been helped by their services. She believes it is more common for the abused women to contact social services rather than being referred by the health care professionals who have the knowledge to detect the need for referral. Because Deb was not knowledgeable about abuse and available resources she did not contact social services:

> That I would be referred to a Social Worker. At least have one interview, you know. Like, it doesn't have to be very intrusive. And without my husband's knowledge and all the things like that. And I could have gotten earlier into the system. I think that would of helped. Of course hindsight is always good. When I look back and there were times when I could have been picked up by the system. But it seems like all the time you get into Social Services if you seek it out. You know, not the other way around, you know, like they don't seek you out. But I think, we're not knowledgeable people. It's easier for the others who have studied it (861-886 B).

Legal System

It was common for the women to be reluctant to legally charge their perpetrators. The reluctance was mainly due to fear of violent retaliation as well as lack of knowledge of their rights and the legal process. Some of the women had positive experiences with the legal system and had faith that the law would act on their behalf. Other women had negative experiences with the legal system. Some women were not believed by the police or encountered an attitude of impatience with them for not leaving the abusive situations. The police officers demonstrated great differences in level of understanding about abuse and the complexities of the leaving process.

A lack of knowledge of the legal process and their rights was a common barrier to the women accessing the legal system. Beth was empowered by the legal information she received regarding her child custody rights:

> He kept telling me that I didn't have any rights to my children. So I went and seen the lawyer and I said, "What are my rights?" And found out I have more rights than he did because we were living together. "He wants rights, he should marry you." So I told him,

> "Don't you ever throw that in my face again, because I know what my rights are" (361-366 A).

Amy was reluctant to charge her partner and it was only after several abusive episodes that she did charge him. Even then, Amy needed to be pressured by police officers to lay charges: "The police really pressured me to charge him this time" (342-343 B). Amy believes charging the perpetrator is effective in stopping the abusive behavior. In her situation, it was the only measure that, at least temporarily, stopped the abuse: "It works. I'm a firm believer. Charge him. It works. You've got the law on your side" (1140-1141 A).

Carla was also reluctant to charge her partner. She would deny that abuse had occurred because she was afraid of violent retaliation from her partner:

> The police were called, I can't even remember how many times. . . . But every time they said, "Are you sure you're okay? You don't want to press charges? Is there any abuse going on at all?" I kind of denied it all. If it wasn't me who was calling the police it would be the neighbors because they'd hear us fighting. But as far as the police were concerned, just from what I would tell them, and all I would tell them is that, "We were just yelling, there was no physical abuse or anything." So I kind of, I stood up for him. Kind of protected his ass for a while. Scared of him. Very scared of him (443-463 A).

However, once Carla did lay charges she had very positive experiences with the police intervention. The police provided Carla with information on available resources and maintained contact which involved an aspect of emotional support:

> I found that they're paying more attention to the abused woman than they are to the abuser. They do more now to protect the abused than they do to protect the abuser. They give you a list of places to go, people that you can talk to, people that you can see, things that you can do. Um, what rights you have and what you are legally able to do to the person who has abused you. So I found it very helpful, they were very courteous. The police that came here were very, very nice, very understanding. The arresting officer and I still stay in contact with everything that's going on. He phones me, asks me how I'm doing. Asks if I'm still going to group and stuff. I have his number at work and I have his pager number if I need to talk to somebody and the police are really becoming aware of women physically abused (483-498 A).

Gina had negative experiences with police officers. She proceeded to the hospital for assistance following an abusive episode but her partner's story of her falling down was believed rather than her story of abuse. As a result, Gina felt helpless to change her situation:

> The police came and they asked me what happened. I told them what my ex had done to me and they said, "Well you know, we just talked to your ex and he said you fell down." I was, oh I was livid again. . . . The doctors and nurses you know, it's like they didn't believe me, you know, it was okay. The policemen went and they said, "Okay, you're free to go." And I was just, I don't know what to do again (806-814 A).

Gina experienced inconsistencies in police responses. In one instance, her partner was not charged because there were no witnesses to the abuse. She was told it was her word against his word. However, charges were laid in another instance of break and enter and abuse, but there were no witnesses present. Gina expresses her anger and frustration with the inconsistencies she encountered:

> Part of my anger is back, still back in (town) with the RCMP. Why didn't they charge him then? You know, I mean the police here,

> they didn't have a witness for the assault, you know, but they still charged him. Because you know, break and enter and what I told them and they still charged him. And I look back (at the) RCMP and I wished they would have charged him (1291-1299 A).

Statements were made by police officers to some of the women which reflected a lack of understanding of abuse and the complexities of the leaving process. Some police officers made statements to the women which reflected an attitude of blaming the victim:

> The RCMP, I was not impressed. I was not, I did not get much, any support from them, I felt. You know, it was the same thing too, I'd tell them, it's like they didn't believe me. You know, they took me out one night and I said I was going and never coming back, but I did come back. And after I came back, their attitude was, "Well you came back. Well we're not going to help you anymore." You know, so if I called them three times after that it was like, "You're asking for it. You know we told you what to do. . . . It's your fault. You know you put up with it. You want to stay here. You keep putting yourself into it.". . . They'd just tell me, "Well, you must like it. You know you've had opportunity to leave. Why didn't you?" (Gina, 159-186 B).

Fay experienced feelings of self blame and guilt following statements made to her by police officers. Fay believed the police officers' simplistic response of "just leave" reflected ignorance about the complexities of leaving an abusive relationship:

> It wasn't until I told the police about it years later that they said, "Well what did you do?" And right away I felt guilty because I didn't report it. I think, "Oh God." And they'd say things, "Well if you were so scared of him why didn't you get the hell out of there?" And I thought, "Well yeah, because he follows us and threatens to hurt everybody and their kids too. I don't think so. And plus nobody is going to let you in their door" (904-911 B).

Gina felt that because she called the police too many times they no longer believed her and were tired of responding to her calls:

> It's like if you cry wolf too many times, you know, and that was my third or fourth time. It's like they don't believe me anymore. You know, the times they'd come out and they'd say, "Well (Gina), he's not here." You know, because every time he knew they were coming he'd run away and hide, you know. And they were getting tired of coming out all the time (224-230 B).

Community

The women accessed a variety of community resources which mainly consisted of support groups, shelters, churches, and counselors at various agencies. The women acknowledged the need to make changes in themselves and their lives. The women had both positive and negative experiences at each type of community resource.

Agencies

Beth initially did not seek counseling for herself. She received counseling indirectly when she took her daughter for sexual abuse counseling. From this encounter she sought further counseling for herself:

> I got help for (daughter) and that is how I got help for myself. She would talk to me as well as (daughter). And this is how I got help for myself. And that is why I'm going to the Sexual Abuse Center, because I don't ever want to live with a man like that again (475-479 A).

Through counseling at AADAC (Alberta Alcohol and Drug Abuse Commission) Fay obtained knowledge of abuse and control: "I went to AADAC. I thought, okay, this is an alcohol problem. Well no, not just an alcohol problem. I sought help. And it was really good. That was the first time I heard the words abuse and control" (645-648 A).

Some of the women talked about the importance of having their experiences of abuse validated by counselors. "As soon as I reached out for professional help and all that, everybody believed me and everybody knew what I was talking about. That was so weird" (Deb, 1359-1361 A). Fay was relieved to hear from the counselors that she was not going crazy when she was experiencing flash backs of abuse: "I'd try to tell the counselors, 'I know I'm crazy because I have hallucinations. I have these, these flashes.' And they said, 'No, that's a sure sign of abuse'" (135-137 B).

With assistance from her counselor, Gina was able to change her perspective of her situation and therefore make positive changes in herself:

> Once a week I'd go see my counselor at AADAC. Now and then the counselor from mental health, I'd speak with her. . . . At AADAC, the counselor there, he was really helpful and he kept me going. . . . You know, a lot of times I just wanted to give up. He kept me going. I think I spent a lot of time focusing on my partner and his drinking and stuff and he helped me with this. And I was trying to change that behavior. But he helped me with this. To give up, I can't change him. The only one I can change is myself. So that's what I was working on with him, was changing myself (26-47 B).

Deb was able to leave her relationship with the support and specific information she received from community agencies:

> She just counseled me. She told me, "Your experience is something that's called abuse. There are shelters. I can get you into a shelter, you and your daughter, right now." And she just got me going and then I got a counselor at the nearest Community and Family Services and they helped to make an escape plan,

> which I did. I got some of my clothes out slowly, slowly. And then I got a lawyer (1379-1386 A).

Support Groups

Several of the women attended support groups for abused women and found it helpful to share their experiences with others. Sharing experiences with other abused women helped them realize they are not alone. "I go to a group for abused women and I have total empathy for them but I just think about everything we've been through" (Ellen, 1062-1064 B).

Amy attended a support group that did not meet her needs. The women expressed a lot of anger and hatred towards men, feelings that Amy did not share:

> I sat around listening to these women just putting them down, they were the scum of the earth and we shouldn't have any men in our lives and we should all be lesbians and just, "Oh man, what am I doing here? This isn't right either. This isn't helping me." So I left (1270-1275 A).

Shelters

Most of the women went to shelters, some women stayed at the shelters more than once. All of the women, except one, felt the shelters effectively met their needs in their time of crisis.

A shelter worker telephoned Deb's husband for her. This was important to Deb because her husband's abusive behavior became apparent to others and her experiences of abuse were validated:

> I let a shelter worker call him. And that was really, really nice, because that confirmed to them, you know, because he just blew up and he said, "Why are you supporting her? She's nuts." Oh,

> he just yelled over the phone and that was really, really good, because he acted like his crazy self, you know and somebody from the outside saw this (1431-1437 A).

Carla found the time spent at the women's shelter to be very helpful. She was given specific advice and guidance on changes to make to improve her situation:

> So the day I got out of the hospital I went directly to WIN House. Three weeks. . . . I got a lot done. I had my number changed. I had my locks changed on my door. I had my bank account changed because he had . . . my access cards. So I got that canceled on him. I put a warning on his account because he knows how to forge my signature, so if he goes through my mail and he tries to cash a cheque he'll get in trouble for it. I'm getting an alarm system. The EDT service, it's a community service that's free for battered women, I'm getting one of them. . . . It was really supportive, they're really helpful (399-417 A).

Beth also went to stay at a women's shelter when she left her partner. However, she returned to her partner after a couple of days, stating she was not comfortable without her things from home:

> So I ended up spending the weekend in one of those abused women's homes. But you know, when you are in those abused women's homes too, you have nothing. I had no money, no nothing. And it's not home. So I went back. Better to be home and in my own kitchen and all that stuff than to be in one of those places (163-168).

It is difficult for women to leave their homes and their belongings. The effectiveness of the time spent at a shelter may be reflective of the woman's readiness and how prepared she is to leave the abusive situation.

Churches

Several of the women had a religious faith. Fay discovered a church that became one of her main supports: "The church I went to just really came forward for us and they became like a surrogate family for me" (362-364 A). She described the valuable counseling and support she received with the help of the church:

> It was that church that offered to make a donation to (agency) counseling so that I could go see a psychologist because I had no means to do that. And it's been a psychologist that specializes with women like myself. . . . Even when it came to, like coming up to the trial. The letters that he writes and like he says, "(Fay), I won't use the battered women's syndrome because they'll turn that back on you, but we can use post traumatic stress syndrome." He's brilliant when it comes to how to best defend me and his willingness to write letters with the lawyers too. To do anything and everything he can (502-515 B).

Prior to accessing a supportive church, Fay had negative experiences with other churches. She shared her beliefs on the role that religion plays in abusive relationships:

> The churches are deadly for battered women. . . . They are still playing the blame game. The only church that I've seen that had taken some definite, correct, safe baby steps would be Central Baptist. . . . The other churches, they wouldn't help at all. A nightmare. It's well, you're supposed to submit to your husband. They never read the second part of the verse, you know, and husbands treat your wives like Jesus Christ treated his church. They never read that part. The attitude is controlling. And that's what I found a lot of churches are mostly interested in doing, is just controlling their flock (308-331 B).

Inadequate Availability of Resources

Once the women finally reached the point of asking for help it was common for them to encounter difficulty accessing the resources. Gina's only support person was a counselor who was often busy so she had trouble procuring his services:

> Really the only person I had was (counselor) at AADAC. You know and I could hardly ever, he was a busy man. I could hardly ever get in to see him or phone him. Other than that I had nobody else. No family. I didn't know anybody and so no. No supports (129-133 B).

Beth was put on a two year waiting list for sexual assault counseling. She fears that without counseling she will continue to enter into abusive relationships:

> That's why I decided to make an appointment with the Sexual Abuse Center. But that was a couple of years ago I think I did that, and they finally phoned me. So I've got an appointment for Monday at three. Because if I ever want a, like I'm lonely. I want a relationship again, right? But nine times out of ten I'll probably get one that is abusive again, right? Because you have to make yourself well. If you don't, you jump right back. It ends up being worse (1434-1441 A).

One night Ellen decided to leave her relationship, but returned to her husband after she was put on hold when she telephoned a women's shelter:

> When I was pregnant with my daughter, in the middle of winter, I did leave him. And I went to a pay phone and I had my son and I phoned WIN House and they put me on hold. And we were in a phone booth in the middle of winter and I had a baby, so I ended up going back (130-134 A).

The night Fay fled with her children all of the women's shelters were full. They ended up staying at a hotel instead, which was terrifying to Fay:

"When the police came to take us out . . . WIN Houses were full. They put us up in a hotel downtown and I was terrified. Absolutely terrified" (1011-1017 A).

The time limit of three weeks at a women's shelter is not an adequate amount of time for all of the women who flee there in crisis. Beth shares her feelings on the inadequacy of the three week time period:

> This is what I hate about these abused women's homes, you are only allowed to stay there for three weeks. Well, you're not in your right mind. You've just left everything behind. And then you go and stay in this home, you don't even have any tobacco, no money, no nothing. Because you're not thinking about the time you're going to leave this guy. So anyway, he has all the money. . . .You are only allowed to stay in these places for three weeks, and then you are supposed to move on. Well, in three weeks you don't even have your head together. It took me three years to get my head together. So I just thought I was stuck (690-703 A).

Beth's experience reinforces the importance of planning, preparation, and readiness for success with leaving an abusive relationship.

In summary, helping professionals have a vital role to play in situations of domestic violence. Detection and appropriate intervention is the key to breaking the cycle of abuse.

Messages for the Helping Professionals

The women made suggestions on ways to improve the care and assistance provided to victims of abuse. Fay expressed her feelings of desperation when faced with an apathetic professional:

> The desperate need for help, for protection, for the encouragement to stop the cycle that's getting worse every generation. Most importantly is for my children and all the children that I've seen. . .

> . I have watched a steady stream of women and children walk through shelter doors and there's nothing as pathetic as a child that normally watched his or her mother being beaten but because they tried to stop it, were beaten too. Their clothes ripped . . . the humiliation and the shame and terror. There's nothing like watching what it's like. The closest I can come to describing it is, I think of places like Auschwitz and the streams of the Jewish people and nobody cared about them either. The worst of it is, we are accountable for what we do to help, even one person. To ignore it is to be just as abusive as anybody else (1147-1162 B).

Education

Education was viewed as the necessary foundation for increasing the awareness of abuse for helping professionals and abused women. Fay believes nursing and medical education should include spending time at women's shelters. Exposure to the realities of victims in crisis would increase the sensitivity of health care professionals to the issues of abuse and foster the development of empathetic attitudes toward the victims of abuse:

> I strongly suggest that there's an awful lot more workshops. That some of these doctors and especially interns, student nurses, are required to spend time in shelters with these women and children. And watch the streams of broken people walk through. And it's women and children. And watch the manipulative devices that the men use to get at these women and children (779-786 B).

Gina believes that women need more education about abusive relationships: "I know better now. But then there's women out there that don't know that yet. And that's hard. More education. More education is needed on abuse" (565-567 B). Deb is one example of an abused woman who did not realize that her relationship was abusive. Subtle forms of education are not effective for some women:

> I find with most of this world of oppressed and abused, we don't look. It really has to be banged into our head, it just doesn't even have to be flashed in front of our eyes, it has to really be dropped heavily on our heads, that kind of information. Because I'm sure I've seen it in doctors' offices, it just never applied to me. I never really looked at it (1550-1556 A).

Attitude

Professionals must remember their responsibility and commitment to assist patients. "I believe that doctors are in the profession, and nurses, because they have sincerely, hopefully I still have this belief, that they're there because they want to help. For them to be willing" (Fay, 790-793 B). Fay did not always encounter professionals who were willing to help her and her children. She adamantly expressed her views on the responses and attitudes of some of the helping professionals: "The ignorance, the apathy in a lot of professionals was a nightmare" (581-582 B). She stressed the need for professionals to consider the women's stories of abuse seriously: "Don't minimize anything a woman tells you and fight against denying the damage that it's doing. Always see the children" (1303-1305 B). She feels there is no excusing professionals who minimize abuse: "When a professional minimizes it, he's just as guilty as the perpetrator of abuse and I have no words for people like that. They're cowards and I feel anger towards them" (815-818 B).

Fay made a plea to professionals to have an empathetic attitude toward victims of abuse. She feels it is particularly essential when the woman is pregnant:

> Put yourself in their position. Make yourself feel somehow what the individual is feeling and if you can't do it for the adult, do it for the child inside. The children receive the blows, the verbal assault, the sexual assaults, the emotional assault. The baby in utero is receiving all of this. That's all they know. It's pretty tough for anyone to even try to believe that that's healthy (592-598 B).

Assessment

It was suggested that an assessment tool be utilized to screen all women for indicators of abuse. Any signs of abuse must be clearly documented:

> Helping professionals must devise a set of questions that must be answered by the patient, must be. They must document red marks, like for example, on the upper part of my arms was where he had held me and picked me up and shook me, like I mean, they hurt so bad and they were all red. Well, doctor, nobody marked that down. Nobody marked the big bruise in the middle of my chest from being punched in the chest. Why not? (Fay, 674-683 B).

Fay described common areas of injury that can serve as indicators of abuse to health care professionals:

> I just can't stress strongly enough, document details so clearly, size of bruises, where they are. When you see a woman, any woman with bruises up here (points to upper arms) you can be sure she's getting abused. You can be sure of it. Because often these guys, they're so in control they know where to grab you where nobody can see it. And most of us have a lot of bruises that are either under our hair, you're not going to see it. Or our arms, sometimes around the neck because they've tried to choke us (864-872 B).

In addition to thoroughly assessing any physical injuries, Gina believes it is important to complete a psycho social assessment of the woman's home situation which includes determining her level of safety and presence of a support system:

> I think if someone came in to a hospital or a clinic when they're pregnant and maybe if something happened to them, they had an injury or something, maybe to follow that up. Ask them, you know, "What's going on at home?" Or, "How are you feeling?" And, "How safe are you?" Or if you have any family or friends, someone you can talk to. Or if there's other support, that kind of stuff (258-264 B).

In hindsight, Gina wished she had received a thorough assessment of fetal well being after she had been physically abused. There were no obvious signs of physical injury to Gina, so she was discharged. However, no attempts were made to assess or meet any of her emotional needs:

> As far as pregnancy, maybe do more tests. I know when I was in the hospital, I had no tests done. I had no monitoring, never had any of that done. You know, just to be on the safe, just to make sure things are just fine. You know, I never had any of that. I think that would of helped to reassure me, you know, everything's fine. Just that telling me, "We don't see anything wrong, you know, physically you're fine. You can go." Just have that assurance, you know, run a test. That would help. It's hard. And you don't have to have bruises on you. Just find out what's inside, you know, instead of looking on the outside for bruises and cuts, you know. Try to find out what's on the inside, how the woman is feeling emotionally (402-415 B).

Deb discussed the need for health care professionals to consider all of the information in a woman's situation so that she receives holistic care. Simply prescribing medication for psychological symptoms was viewed as insufficient care, as the underlying cause is not addressed:

> It's clients that you have for a long time. And you know, when there are things like anxiety and depression, like I think it's important to check this out a little bit further. I know it's very easy to say, "Well, we'll give you medication once and that's it." But there is more underlying. Or send them to a counselor, things like that (833-839 B).

Intervention

Beth expressed her need for emotional support from the helping professionals. It was important for Beth to be told by a professional that she was not crazy, during a time that she thought she was:

> Just a friend to cry on. A professional to say, "You are not crazy." This is why, I didn't know how I was feeling. I know now because I've been gone for three years. But at the time I didn't know why I was doing all this stuff (861-864 A).

Fay discussed the need for professionals to willingly become legally involved in cases of abuse:

> For doctors to have documented what they saw and when they knew it. It was like diagnosing a boil, you know, like if you see a hand mark bruise, it's a hand mark bruise. If you see, you know that the injury has been caused by being hit with an object . . . document it. And nobody wants to. That's the thing that kills me. How many doctors absolutely refuse. And I feel angry about that because it's like everybody is protecting their own butts but who's protecting the kids? Because that's what it's going to boil down to (547-559 B).

Fay believes professionals are reluctant to get involved because of the possible legal ramifications to them as individuals. She wonders if the professionals had legal protection they would be more willing to become involved and support the victims of abuse:

> And to have some kind of protection for doctors and nurses, for the professionals. That when they do step forward and testify,

> there is some kind of coverage for them. That they're not going to be threatened or you know, lawsuits brought against them or anything else (793-798 B).

In summary, one of the main motives for the informants to participate in this study was to send messages to the helping professionals. They openly shared their experiences in the hope that a greater understanding would lead to improved care for victims of domestic violence. Further education was identified as fundamental. An empathetic attitude and approach is essential when providing care. A willingness for helping professionals to become involved in breaking the cycle of abuse is desperately needed.

Life After Leaving the Relationship

The women shared their feelings on how their lives have changed for them and their children since leaving their abusive relationships. Although some of the women still feared their abusive partners, they felt a sense of peacefulness that they never thought they would find.

Life is Better Now

The general themes of the women's descriptions on how their lives have changed since leaving their abusive relationships include coping well on their own and feeling less stressed. "Finally, being here for eighteen months now, that's the only peace I've known in a lot of years" (Beth, 1504-1505 A).

Amy described the personal changes she has undergone and how her life has changed since leaving her abusive relationship. She hopes to marry her fiance before her perpetrator is released from jail:

> I've turned my life over to Jesus Christ, you know, I'm a born again Christian now. I met a wonderful man and we're getting married in a couple of months. Hopefully before he (perpetrator) gets out (of jail). And we have started a new life together (1195-1199 A).

Beth's description reflects her understanding of how difficult it is for abused women to feel as though they can leave an abusive relationship but she wanted women to hear her message that life is better after leaving:

> Now I find out I'm making out quite well and there's a hell of a lot less stress. But try to instill that in someone that's being abused, that's going through an abusive situation. Try and instill that in someone because they think they're worthless. . . . See, without this man, I'm nothing. So you know, there's no way unless he dies or something like that, that you can get that person away, unless she wakes up and says, "There's a better life out there for me" (529-540 B).

Better for the Children

Many of the women tolerated their abusive situations when they believed that they were the only person being affected by the abuse. Once the women realized the children were also being affected by the abuse they decided to leave the relationship.

The women's dedication to their children was apparent as they talked about their roles as mothers. "It's that basic instinct that comes back. And I think that's probably why motherhood is really important to me too, because that is like my first and most important job" (Ellen, 1172-1175 B).

Protecting their children was identified as one of their most important roles as a mother. "My kids are never going to go through this again. I'm going to make damn sure of it" (Carla, 1272-1274 A).

The women identified immediate and long term negative effects the abusive environment had on their children. Fay realized that by staying in an abusive relationship she was teaching her children to accept and tolerate abuse: "You know what I taught my children? To shut up and put up" (538-539 B).

The women talked about the positive effect leaving has had on their children. By leaving her abusive relationship, Beth believes her children have directly benefited: "By leaving him I gave them a better chance because they don't see that dysfunction" (974-975 B). She believes that raising her children in a single parent family is better than raising her children in an abusive environment:

> And they can't watch Daddy saying to me, "Oh this is your stupid mother. Your mother's nothing but an alcoholic." And stuff like this. . . . Least they don't have that around. I don't know how good of a job I'll have raising them by myself, but I'd rather raise them by myself than have them in that kind of situation. So they can go into marriage and not know whether it's normal or whether it's right (938-948 B).

Several of the women focused on their concerns of the effect that staying in an abusive relationship would have on their daughters' development as women. When Deb realized that her daughter was cognizant of the abuse in the home she felt she had to protect her daughter and foster her positive development as a woman by leaving the relationship:

> I really, really tried to think, well, it didn't affect her and so I can stay. And then at the end, it was the last year, I saw it. I knew it. You know, if I can't protect her, like, what is she going to think about growing up and stuff? This is not what I wanted her to be (635-639 B).

The women wanted to be good role models for their daughters. "I think, what if my daughter is going to sit down ten years from now and say, 'How come my mom married this man?'" (Ellen, 910-912 A). They did not want their daughters to repeat the cycle of abuse:

> Being told I'd never get out alive. Never to get out of there again alive if I'd gone back. You know, and for me it's always well, who'll teach my children that this isn't right? I don't want my daughters to be treated like that. I want them to be loved like they're supposed to be loved. Like, the partnership and respect and enjoy life. To enjoy who they are. To be a person with a social conscience, of courage. I want them to have the supports to know that they can keep fighting (Fay, 961-972 B).

Decisions related to whether the abusive partner continued to have contact with the children varied with each woman's unique situation. Carla was adamant that her partner would have no further contact with her children. Her partner had physically abused her son and directed abuse toward the baby while she was pregnant. At the time of the interview the possibility of sexual abuse was being investigated: "No, no, no. Not with the possibility of sexual abuse to (son). Forget it. No. I won't even allow supervised visits. There's no way" (1237-1239 A).

Although Beth's oldest daughter from a previous relationship had been sexually assaulted by Beth's partner, she agreed to his supervised visits with the two children he fathered:

> I was willing to give him reasonable visitation rights. I don't believe like a lot of people, they take things, the children. "You can't have that child because I want to punish you." I don't believe in stuff like that. I believe the children should get to know the father (1041-1046 A).

Amy's partner had not been directly abusive to their children and wanted to be a good father to them. She had accepted that he will always be in their lives. At the time of the interview the children maintained contact with him while he was in jail on assault charges: "I'll never be able to keep him from the kids" (740 A).

In Hindsight

Many of the women talked about being able to clearly see the situation only after they had left the abusive relationship, as Amy explains:

> And I never realized it until now. Until afterwards. After I got out of the situation, my eyes were opened, my sights were clear. And that's what it took to get him . . . out of my life, you know, to realize some of those things (597-601 B).

Gina expressed feelings of guilt for returning to the relationship which resulted in the stillbirth of her daughter. It was this event that helped Gina to realize the extent of the abuse and subsequently to leave the relationship:

> It's unfortunate I had to go through the loss of (daughter) in order to realize what was going on. And as I look back, how many times I went back to him, you know. I think . . . what have I done? It was part of the process (1217-1221 A).

Ellen experienced memory loss of the abusive incidents which enabled her to deny the reality of her situation. Ellen believes her denial of the severity of abuse contributed to her staying in and entering into another abusive relationship:

> Because I didn't remember, I didn't realize how bad it was. I didn't think how bad it was. And that's probably why I kind of got into another relationship like that. Saying, "Oh, it's not that bad. It's not this or it's not that, the same as the other relationship was." But I think that's why I don't want to remember things. He did some . . . things that I remember and that I don't want to remember too. And I can't even talk about it. It's just I didn't even know what he was doing when he did it until a year after I realized why he did things (870-886 A).

Fay's acceptance of the abusive relationship for many years was possible by her belief that things will improve some day:

> Seems so dumb when I think about it now, you know. When I look back at this, how he controlled everything I did, it's really hard to believe that I didn't know what this guy was doing. Except I just kept thinking we'll find a better way (739-743 A).

Deb reflected on the difficulties related to leaving an abusive relationship and the difficulty of others in understanding why women do not leave abusive relationships:

> Now I have been faced also with having girlfriends that I have met at the shelter and they have gone back and I don't understand. I don't want to be patient. I want to just yell at them and some of them I actually don't even keep contact, because I can't deal with it. I just can't deal with it. Them trying to idealize the situation and I can see it very clearly. So I understand now. I understand both sides (1288-1295 A).

No wonder it is difficult for helping professionals to understand why abused women remain in or return to their abusive relationships. The victims are also confused and overwhelmed with the issues and obstacles they face.

Conclusion

The women who participated in this study broke the silence about the abuse they experienced during pregnancy. They shared painful memories about their shattered dreams and the humiliation they endured. Although their individual experiences were unique, common themes were identified in their stories.

All of the women had left their abusive relationships at the time of the interviews. It was in hindsight that the women were able to discuss their experiences with a sense of clarity which they felt they did not possess while living in their abusive environments. The women acknowledged that they were in the process of healing and believed their participation in the study facilitated the healing process. They had also reached a point in their lives where they were capable of and wanted to assist other abused women.

Abuse is both complex and subtle, and the women in this study weave a web of deception in order to protect themselves and their children from the threats of the abuser. Pregnancy becomes a feared rather than a wanted event. As helping professionals, we can gain valuable insight into the complex dynamics of abusive relationships and how pregnancy further compounds an already volatile situation. Valuable information can be gleaned from the women's stories and implemented by helping professionals to assist victims of domestic violence.

CHAPTER V

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

The purpose in this study was to explore and describe women's perceptions of their experiences of being abused during pregnancy. The goal of the researcher was to expand nursing knowledge in the area of abuse during pregnancy. It became apparent from the women's stories that abuse during pregnancy occurred within the context of their abusive relationships. Therefore, the findings of this study did not focus solely on the abuse experienced during pregnancy, but rather, reflects the women's stories of their experiences within the broader context of their abusive relationships.

The effectiveness of the data collection and analysis methods used in this study will be discussed. Conclusions will be presented and the findings will be discussed in relation to the findings of other studies conducted in related topics. Limitations of the study, suggestions for further research, implications for helping professionals, and a summary will then be presented.

Discussion of Research Method

As presented in Chapter III, an exploratory descriptive approach using ethnographic methods facilitated the emic perspective of the women's experiences of abuse during pregnancy. This approach was selected because little information was known about women's experiences of abuse during pregnancy. Allowing the participants to tell their stories fostered the emergence of common, relevant themes and categories about their experiences without being influenced by the researcher's preconceived ideas about the phenomenon. The purposive model allowed for the identification and relationships between categories and sub-categories while maintaining the uniqueness of each woman's experience.

Although several recruitment methods were planned, placement of an advertisement in a community newspaper proved to be the most effective method. Advertisements posted in WINGS Second Stage Housing and announcements made at a women's follow-up support group were also effective in eliciting responses. Although access for recruitment was granted by other agencies, it was not necessary because an adequate number of volunteers had already been obtained.

The informants varied in terms of age, length of time spent in abusive relationships, number of abusive relationships they had been involved in, length of time since leaving the relationship, number of pregnancies, types of abuse experienced, income, educational background, employment, and health problems. One informant was pregnant at the time of her interview. All informants had left their abusive relationships at the time of interviewing. One informant indicated that she was considering returning to her abusive partner. The diversity within the informant population supported the process of purposive sampling.

Open ended interviews were conducted with seven informants. All of the informants were interviewed twice, except one informant, who was interviewed once due to complications that developed with her pregnancy. The women who participated in the study were highly motivated women who readily and openly shared their experiences. They believed the topic was important and were appreciative of the opportunity to tell their stories. They hoped this study would assist other abused women.

The open ended interviews produced rich data; the abuse the women endured was a significant life experience. The quality of the data was enhanced by the face to face interviews as rapport was established between the participants and the researcher. Communication of the emotional context of the women's statements and the researcher's sensitivity to their stories was facilitated by the face to face contact. The women welcomed the opportunity to tell their stories in a venue that involved being listened to but not being judged.

During the data collection and analysis stages methodological rigor was enhanced by adherence to ethnographic methods such as purposive sampling of credible informants, open-ended interviewing, and thorough documentation and coding. Feedback was provided from the thesis supervisor throughout the data collection and analysis phases to minimize the risk of researcher bias. Research findings were verified by secondary informants. Since collecting and while analyzing the data my clinical practice on a tertiary care labor and delivery unit has provided numerous opportunities to interact with women who were abused during pregnancy, these interactions have also served to validate the findings of this study.

Measures to protect the confidentiality of informants and the data were strictly adhered to during the research process. Safety measures were planned and implemented to enhance protection for the informants and the researcher. Breaches to confidentiality or safety did not occur during the course of the study.

Limitations of the Study

At the time of interviewing the informants were homogeneous because all participants had left their abusive relationships, a different perspective may have been obtained from women currently involved in such relationships. As well, all of the informants had accessed resources. The perspective of women who have accessed resources for victims of abuse may vary from that of women who have not accessed these resources. However, despite this homogeneity, informant diversification existed on several demographic variables.

All data on pregnancy, with the exception of one woman, was obtained in hindsight. Carla was the only informant who was pregnant at the time of the interview. Obtaining the perspectives of other pregnant women would add valuable information to the phenomenon of abuse during pregnancy.

A strength of the study was allowing the informants to choose the location of the interview. This enabled the women to be interviewed in a setting that was both convenient and safe for them to disclose sensitive information.

Discussion of Findings

The informants' stories provided valuable insight into the issues commonly faced by women abused during pregnancy. Helping professionals can utilize this information to improve the care provided to this high risk population. Recommendations for practice and education will be presented based on the women's experiences and the findings of other research studies.

The Experience of Abuse

The women's stories were told within the context of their abusive relationships. They described their family upbringing and reflected upon the characteristics they possess as adults. An association was made, as they implied that their childhood experiences greatly influenced who they had become as adults. Amy, Beth, Carla, Ellen, and Gina had been involved in more than one abusive relationship. Beth, Fay, and Gina experienced abuse as children within their families of origin. Other researchers have reported that victims of domestic violence are more likely to have been abused as children and to have witnessed parental violence than those who have no history of violence (Buel, Candib, Dauphine, Sassetti, & Sugg, 1993; Evins &

Chescheir, 1996). Studies have found the occurrence of child abuse or wife assault in the battered woman's family of origin to be as high as 67% (Walker, 1984).

The women's stories also included descriptions of their partners' family upbringing. An overwhelming commonality was a history of dysfunctional family upbringing. Amy, Beth, Deb, and Fay described their partners' family of origin as dysfunctional. Amy and Carla stated their partners were fatherless during childhood. Perpetrators are more likely to have witnessed domestic violence in their homes or to have been abused as children (Evins & Chescheir, 1996). The childhood experience of witnessing wife assault has been shown to have a significant impact on future interpersonal relationships. Reports from those working with batterers indicate that 80% of the men had witnessed wife abuse or had been abused as children (Walker, 1984).

The women's descriptions of the dynamics of their abusive relationships fit with patterns of violent families found in other research studies. It was common for the batterers to minimize their problem, abrogating responsibility. The women reported a tendency to accept blame and feel guilty. Over time the men became more controlling and excessively jealous of the women's outside contacts. As a result, the women lost contact with social supports and became isolated from people who may have been able to help them deal with the abuse. As this pattern became more established, it became increasingly more difficult for the women to alter it. Bain et al. (1991) report similar patterns from studies conducted on violent families.

All forms of abuse, originally identified in the definitions, were experienced by the women in this study. From the women's descriptions an additional form of control, financial abuse, was identified. The findings of this study support the significance of this form of control and the need for its inclusion in descriptions of abused women. The typical repetitive worsening course of abusive behavior was apparent in their descriptions. The violent outbursts occurred intermittently and often unexpectedly. The informants' reports of an escalation in severity and frequency of abuse over time is a pattern well documented in the literature (Parish et al., 1996).

Common traits of the perpetrators identified by the women, such as excessive jealousy, overpossessiveness, a desire to control, impulsivity, a low frustration level, and drug or alcohol use are similar to those found in other studies (Moss & Taylor, 1991). The women described their partners' behavior as unpredictable. The perpetrators had both a private and public persona which enabled them to manipulate others. The attacks typically began with verbal abuse and minor injuries, proceeding to more serious injuries and threats. This pattern of abuse is a common finding in other research studies (Bain et al., 1991). Initially the batterers used promises to keep their partners from leaving them. During the period of remorse Amy and Gina's partners begged for forgiveness, promised it would never happen again, and declared their intent to receive counseling. Beth, Deb, and Fay described their partners' indifference toward them after the affection died. As the abuse escalated, threats were used to keep the women from leaving. Beth, Deb, and Gina were threatened with losing custody of their children. Amy and Fay received death threats from their partners.

Although the forms of abuse varied in time and intensity during a couple's life and from one couple to another, the women's descriptions reflected the three phases of the cycle of violence as described by Hutchinson (1988, as cited in Parish, et al., 1996). Phase one, the tension phase, is characterized by several incidents considered as minor by the victim. She believes the situation is temporary and that she will be able to control it. Initially, Carla thought her partner was just "fooling around". In phase two the violence explodes. There is a short, serious episode in which the batterer loses control. Beth described her shock and disbelief the first time her partner hit her across the face. The last phase is a period of calm and reconciliation. The batterer seeks forgiveness, the woman is hopeful and wishes to forget. This period varies in length and may not occur in all couples. The cycle repeats, with phases coming closer together, and the incidents becoming more serious (Parish et al., 1996). Recognition of the harmful and potentially fatal effects of abuse is essential as the injuries inflicted can become serious enough to cause death. Greater than 40% of

Canadian female homicide victims are killed within a family context. In 1988, ninety seven Canadian women were killed in domestic disputes (Statistics Canada, 1989).

Abuse and Pregnancy

The women responded to their pregnancies with despair rather than joy because they knew that their relationships were dysfunctional. In common with other research findings, the women wanted an end to the violence, not the relationship. McFarlane (1992) has also reported that battered women often perceive that they have few options, and that pregnant women may perceive even fewer. All of the women, except Amy, who became pregnant within six weeks of meeting her partner, reported the occurrence of abuse prior to pregnancy. Prevalence trends in other studies reinforce the correlation between prior abuse and abuse during pregnancy (Evins & Chescheir, 1996; Helton et al., 1987a; Parker, McFarlane, Soeken, & Bullock, 1994). This finding is a strong indicator that a lifetime history of abuse or a history of abuse within the past year should be regarded as a red flag regarding potential ongoing abuse during pregnancy (Evins & Chescheir, 1996).

All of the pregnancies were unplanned. Deb and Ellen were taking measures to prevent conception. Deb, Gina, and Ellen reacted to pregnancy with denial. A study conducted by Stewart and Cecutti (1993) found that almost 89% of women abused during pregnancy had unplanned pregnancies.

These findings are similar to another study in which unwanted and mistimed pregnancies accounted for approximately 70% of women reporting violence. Women with unwanted pregnancies reported significantly higher rates of physical violence (12.1%) than women with intended pregnancies (3.2%) (Gazmararian et al., 1995).

Pregnancy added an additional complication to the womens' lives. They felt trapped in their relationships with the child serving as a permanent tie to their partners. They fantasized about spontaneously aborting the pregnancy, the easiest solution to their difficult situation. The unplanned and undesired pregnancy led five of the women to consider termination of the pregnancy. A study conducted by Hillard (1985) found a significantly increased number of pregnant women currently in an abusive relationship considered abortion (34%) when compared with non abused controls (21%). When Gina requested termination of the pregnancy she was four and a half months gestation but her physician refused the request. Amy had a therapeutic abortion which she felt was a necessary step in leaving her partner. It is evident from this that women seeking therapeutic abortions should be screened for abuse, this finding is supported by the work of Evins and Chescheir (1996) and Hillard (1985).

Five of the women identified changes in the abusive pattern when they became pregnant. However, the abuse Amy and Gina experienced continued to be directed toward them and did not change in focus or intent as a result of the pregnancy. These findings indicate the need for helping professionals to view each woman's abusive situation as unique and recognize that women's responses to abuse will vary.

The perpetrators differed in their responses to pregnancy. Amy and Gina's partners wanted to be fathers and strongly opposed the women's desires to terminate their pregnancies. Beth, Carla, Deb, Ellen, and Fay identified changes in the pattern of abuse with the pregnancy. Beth's partner punished her for being pregnant. Deb's partner withdrew emotionally and physically from her. Beth, Deb, and Ellen's partners denied paternity and insisted the women have a therapeutic abortion. Denial of paternity and accusations of infidelity have previously been reported as a common response of abusers to pregnancy (Parker, 1991). Carla's partner directed the abuse toward the fetus in attempts to terminate the pregnancy. Fay's partner was sexually violent, which she believes were attempts to terminate the pregnancy. A study conducted with a postpartum sample of 488 women reported that 29% of the women abused during pregnancy experienced an increase in abuse during the pregnancy period (Campbell et al., 1992). Helton et al., (1987a) found 29% of a sample population of 290 pregnant women also reported an increase in abuse with pregnancy. Stacey and Shupe (1983) found that out of 542 battered women, 42% had been abused during pregnancy, 8% experienced obstetrical complications, and the majority reported an escalation of abuse during the pregnancy and the child's infancy.

The risk to the fetus may be recognized more readily by women who identify a change in focus of abuse toward the fetus or the pregnant state than women who notice no change in the abusive behavior. This connection is significant because identification of the detrimental effects on the child motivated the women's decision to leave the abusive relationship to protect their children.

The women reported both minimal and excessive involvement of the perpetrators during pregnancy. Absence of a partner or lack of interest can serve as cues of a dysfunctional relationship to helping professionals. Ellen, Deb, and Beth's partners were not involved, viewing pregnancy as the women's problem. The perpetrators either did not attend prenatal classes or physician appointments, or were very reluctant and sporadic in their attendance. Beth and Deb stated their partners lacked empathy for the discomforts they experienced during pregnancy. Beth, Deb, and Fay described their partners as "visiting" them in the hospital, with the birth process being considered as an inconvenience. Amy and Gina's partners were present for their labor and delivery but were unsupportive and abusive. A partner who insists on remaining with the woman during her contact with helping professionals should also raise suspicion. Gina's partner would not allow her to see her physician alone which prevented her from responding truthfully. She believed he was afraid that she would disclose the abuse.

Effects of Abuse on Pregnancy and Women's Health

The women were able to identify the impact of abuse on their pregnancies and general health. The common themes developed from their descriptions will be related to the findings of previous studies.

The seven women received medical attention throughout their pregnancies, often against the wishes of their partners. It was common for the perpetrators to minimize the women's discomforts and concerns. Ellen's partner initially refused to take her to the hospital following a motor vehicle accident and later would not allow her to be admitted for threatened preterm labor. When Gina experienced severe abdominal pain her partner instructed her to wait and she was unable to contact him for several hours. She was later diagnosed with abruptio placenta.

The women did not readily disclose the abuse to their primary care physicians at the onset of their pregnancies. Fay stated she would change physicians frequently in attempts to keep the abuse hidden. Other studies have found abused women to have a greater tendency to miss appointments, switch doctors frequently, and to be almost twice as likely as women who are not abused to delay prenatal care until the third trimester (McFarlane et al., 1992). The associated power and control of abuse may function as a barrier to accessing prenatal care through forced avoidance.

Abused women have reported being prevented by the perpetrator from completing essential care behaviors such as filling prescriptions and returning for appointments. Early identification and interventions for smoking, substance abuse, anemia, infection, and poor weight gain are prevented by the late entry to prenatal care (McFarlane et al., 1996.)

The seven women reported detrimental effects of abuse on their emotional and physical well being. Both acute and chronic conditions were reported. Physical injuries included lacerations, concussions, contusions, fractured thumb, and perforated tympanic membrane.

Following a battering incident, spontaneous abortions, stillbirth, and preterm deliveries have been reported by abused women (Dobash & Dobash, 1979; Hilberman & Munson, 1978; Martin, 1976). Violence has been associated with preterm labor, low birth weight, abruptio placenta, fetal injury, and fetal death (Goodwin & Breen, 1990; McFarlane, et al., 1996; Parker, 1995). Pregnancy related complications experienced by the women included excessive nausea and vomiting, chronic urinary tract infections, antepartum hemorrhage, abruptio placenta, preterm labor, preterm births, small for gestational age infants, pregnancy induced hypertension, stillbirth, spontaneous abortions, post cesarean section wound infection, post-delivery hemorrhage, post-therapeutic abortion hemorrhage, and sexually transmitted diseases.

"Birthweight is the single most important determinant of survival and healthy growth and development for children" (McFarlane, 1992, p. 207). Abuse during pregnancy has been strongly associated with low birth weight infants. A study conducted by Bullock & McFarlane (1989) of 589 postpartum women found 12.5% of the battered women delivered a low birth weight infant compared to 6.6% of the non battered women. Women who reported abuse at the first prenatal visit had significantly lower birth weight than women reporting abuse beginning later in the pregnancy (McFarlane, et al., 1996). Ellen and Gina had low birth weight infants. Deb believes her stressful situation contributed to excessive nausea, vomiting, and the resultant weight loss she experienced during pregnancy.

Fay was hospitalized for antepartum hemorrhage associated with abruptio placenta which she believes was caused by violent intercourse. Following an abusive episode, Gina's pregnancy ended in a stillbirth as a result of abruptio placenta. Amy contracted several STDs during her pregnancy from her unfaithful partner. Battered women are at increased risk of STDs because having multiple sexual partners is often a part of the pattern of abuse exhibited by male batterers (Amaro et al, 1990; Campbell & Alford, 1989). The diagnosis of an STD during pregnancy is so frequently associated with abuse that the issue should always be addressed.

All of the women suffered psychological trauma as a result of the abuse they endured. The common manifestations included low self esteem, anxiety, panic attacks, insomnia, feelings of isolation and stress, depression, and suicidal tendencies. These findings are similar to those of other studies (Council on Scientific Affairs, 1992). A study conducted by Hillard (1985) of 742 prenatal clients found that 20% of the abused women had attempted suicide. Results of a study conducted by Amaro et al. (1990) of 1,243 pregnant women indicated that abused women were at a greater risk for a history of depression and attempted suicide. They have more depressive symptoms, report less happiness about being pregnant, and receive less emotional support from others for the current pregnancy. The emotional trauma is associated with sub optimal self-care and difficulty mastering the developmental tasks of pregnancy, including bonding with the infant (Amaro et al., 1990; Stark et al., 1979; Stark et al., 1981). Beth stated she did not care whether she or her children died. The perpetrators used the women's unstable emotional states against them, accused them of being unfit mothers, and threatened to take custody of the children.

Findings from previous studies have indicated that women who are abused may be more likely to self-medicate with alcohol, illicit drugs, and tobacco to cope with the abuse (Amaro et al., 1990; Bain et al., 1991; Campbell & Humphreys, 1993; Campbell et al., 1992). Five of the women smoked cigarettes. Beth reported using alcohol to numb the painful reality of her situation. Beth and Deb were prescribed anti-depressant medication.

None of the women reported use of illicit drugs, however all of the perpetrators had a history of alcohol or substance use.

Implications of the Findings for Helping Professionals

The women were motivated to participate in this study by the desire to send messages to abused women and to helping professionals. The findings from this study strongly indicate the need for an interdisciplinary approach to domestic violence and a heightened awareness by society. Given the detrimental effects of domestic violence on the emotional and physical well being of women and fetuses, all battered pregnant women need to be considered a high risk (Christian, 1995). The women's stories contribute greatly to sensitizing society to the complex issues faced by abused women during pregnancy.

Implications for Practice

Screening

Helping professionals must get involved. The women are asking for help and they deserve no less. Abuse during pregnancy is a serious societal problem and yet remains a frequently undetected risk factor in a large number of pregnancies. A study conducted in Vancouver found with direct questioning that 20% of the families utilizing a local family service agency had a history of domestic violence. However, only seven per cent of families had been identified prior to the direct questioning (Downey & Howell, 1976). It is only through the intervention of assessment that the cycle of abuse may be interrupted through referrals and education for the victims and perpetrators. The focus of abuse intervention is safety (McFarlane & Parker, 1996).

The informants had contact with helping professionals during their pregnancies, however they reported that they were not consistently assessed for abuse, often despite indications which they believed should have raised suspicion. They attributed these responses to the helping professional's lack of knowledge, lack of concern, or reluctance to become involved. Amy wished the health care professionals who were caring for her had intervened when her partner was abusive toward her during labor and delivery. They witnessed the behavior but failed to act.

It is recommended that all pregnant women be screened for abuse. Victims of domestic violence can not be stereotyped, making recognition difficult. A high index of suspicion is warranted when caring for pregnant women, keeping in mind the woman and her partner may deny abuse or try to minimize the extent of the injuries (Bain et al., 1991). There is some indication that pregnant women are at an increased risk of violence (Berenson, San Miguel, & Wilkinson, 1992; Berenson, Stiglich, Wilkinson, & Anderson, 1991; Campbell et al., 1992; Helton et al., 1987a; Stewart & Cecutti, 1993; Webster, Sweett, & Stolz, 1994). For detecting abuse, direct nursing interviews have been found to be more effective than written patient self-reports. Direct interviews allow for the development of rapport and trust to facilitate the flow of sensitive information (Bradburn & Sudman, 1981; McFarlane et al., 1991; Strauss, Gelles, & Steinmetz, 1980). The findings from several studies were synthesized by Gazmararian et al. (1996) to examine the prevalence of violence against pregnant women. Higher prevalence rates were reported in studies that asked about violence more than once during a detailed in-person interview or when respondents were queried in their third trimester. The lowest prevalence rates were reported in studies in which the women were provided with a self-administered questionnaire by a non-health care professional.

It is recommended that screening for abuse be conducted on every pregnant woman during each contact with health care professionals. Due to the private nature of this crime and the women's fears about disclosing, the detection of abuse is impeded. Most authorities agree that violence against women is a crime that is under-reported (Parish et al., 1996). The need for repetitive questioning of women about abuse is supported by the findings of previous studies. Findings from other studies have shown that the highest prevalence rates are found when the women are queried systematically about violence at more than one point during prenatal care. The following two hypotheses are offered to explain this phenomenon: a) the prevalence of violence increases throughout the pregnancy, or b) a trusting relationship with the helping professional develops over time to a degree that the woman feels comfortable disclosing the abuse (McFarlane et al., 1992). The woman's readiness to change her situation is a factor that must be understood and respected by helping professionals.

Some cases of abuse may be obvious, the woman may openly admit to the problem. After a severe assault Carla openly informed her physician that her partner had beaten her. However, due to the private, sensitive nature of the crime, the majority of victims may attempt to keep the problem hidden. Ellen covered up the abuse by telling her physician that she broke her thumb by dropping a coffee table on it. The reasons for not disclosing are numerous and varied. Ellen feared that disclosing would make the situation worse. Deb was financially dependent upon her husband. Fay feared for her life. Deb and Beth were unaware of their legal rights. Beth, Deb, and Gina feared their partners would take custody of their children. All of the women hoped the situation would improve and felt they had to keep the family together. These reasons for not disclosing are similar to findings from other studies (Bain et al., 1991).

Non judgmental Approach

Because few women will disclose spontaneously, helping professionals must provide an environment in which disclosure becomes possible. A non judgmental and non threatening style of interaction and history taking followed by direct questioning in a private setting is required (Bain et al., 1991). Asking direct questions, such as "Has anyone harmed you?", has been found to be more effective in obtaining truthful responses than indirect, open-ended questions which are more likely to elicit vague responses (Jezierski, 1994).

Helping professionals must demonstrate a willingness to listen. The women provided several examples of not being listened to or not being believed by helping professionals. Gina disclosed to a social worker, telling her that she was afraid to return to her partner. The social worker believed Gina's partner instead of her. It is critical that helping professionals let a battered woman know that you believe her when she reveals she has been abused (Bain et al., 1991). Fay would not disclose to an emergency room physician because she knew by his indifferent manner that he did not care. It is important for the woman's experience to be validated. Helping professionals must reinforce that abuse is a crime and the woman is not be blame. It is appropriate for helping professionals to express their concerns in a gentle, sincere manner that reinforces the woman is a worthwhile person. A woman who feels criticized may seek care elsewhere, where her abuse history is not known (Bohn & Parker, 1993).

Red Flags

Health care professionals need to be knowledgeable about the types of injury associated with abuse. The potential for morbidity and mortality clearly indicate the essential need for helping professionals to become more adept at identifying victims of abuse (Parish et al., 1996). Previous studies have found pregnant women to be at particular risk of injury to the chest, breasts, and abdomen (Bain et al., 1991). The findings of this study are dissimilar with the main sites of injury being the head, neck, and abdomen. It is possible that this is due to the small sample size.

There are physical and psychological indicators which can serve as "red flags" for abuse. Physical injuries that do not fit with the explanation of occurrence should be further investigated. Acute physical injuries commonly seen include multiple injuries which cluster around the head, face, throat, chest, and abdomen. Types of injuries commonly seen include abrasions, contusions, burns, perforated tympanic membrane, fractures of the jaw, clavicle, ribs, strangulation marks, and evidence of rape. (Bain et al., 1991; Parish et al., 1996) Simply prescribing medication to treat the physical symptoms is inadequate. It is essential to explore psychological issues. Psychological cues may include multiple visits to an emergency unit, history of suicide attempts, substance abuse, depression, anxiety, and chronic pain without identifiable cause (Bain et al., 1991; Parish et al., 1996). If the helping professional does not feel comfortable dealing with victims of violence, they should refer to other professionals with the appropriate expertise and experience (Bain et al., 1991).

Protocols for assessment and intervention that integrate all areas must be developed to achieve healthy outcomes for pregnant women and their infants. For example, abused women are more likely to use smoking, alcohol, and illicit drugs to cope with the stress of abuse. If they are living in fear of trauma and homicide, they can not be expected to decrease or cease the use of substances until the underlying stress is decreased (McFarlane et al., 1996).

Documentation

Thorough, objective documentation of the nature of the presenting situation is essential. Fay's injuries were not documented and she adamantly stressed the importance of such records for legal proceedings. The date, time, and location of the injuries with specifics of the battering incident, for example how many times the victim was hit, needs to be included. The use of any weapons and the type and nature of threats to the women's safety should be recorded. Body maps are valuable tools for specifying the location and extent of injuries. In addition, photographs of the woman's injuries may be taken with her consent. It is suggested that the photographs be dated and signed by the victim and the photographer. Written records may be helpful in any future legal proceedings. When Ellen returned to the hospital to obtain a statement about the abuse from the nurse, the nurse told her she did not remember the incident. Helping professionals should be willing to provide statements and be available for court appearances (Bain et al., 1991; O'Shea, 1996).

Empowerment

The woman's awareness of community support services must be explored. Deb was unaware of the resources but once a counselor informed her of her rights, assisted her to formulate an exit plan, and informed her of resources available she was empowered to leave her situation. Specific information should be given about resources, including telephone numbers and addresses. Inform the woman the abuse is unlikely to stop without intervention and is likely to escalate. Discussion of the victim's options and the resource information given should be documented.

The woman's perception of her own safety should be ascertained and an exit plan formulated. Suggestions of items to pack should include: a change of clothing; extra house and car keys; necessary medications; cash; cheque book; bank account book; identification papers; birth certificate; social insurance card; driver's license; and financial records such as mortgage papers, rent receipts, and automobile titles. A plan of where to go and how to get there, regardless of the time of day, should be made (Bain et al., 1991; Parish et al., 1996). The woman should be informed that she may be at increased risk of serious harm or death if she leaves and be provided with information on shelters (Bohn & Parker, 1993).

Knowledge of Legal Rights

It is important for helping professionals to be knowledgeable about violence and inform victims of their legal rights. Women should be made aware that abuse is a crime and informed of their option to notify police. Beth and Deb delayed contacting police because they were uncertain of their rights. Health care professionals are not mandated to report domestic violence, except for cases involving child abuse. Battered women are at the greatest risk of homicide when they leave the perpetrator or inform him that they are ending the relationship (Hart, 1988). The criminal justice system can not guarantee the woman's safety, therefore the woman has the final choice about whether to contact a law enforcement agency. Amy believes charging her perpetrator resulted in a decrease in the violence and facilitated her efforts to leave the situation. Research indicates a decrease in violence in some cases after charges are laid, regardless of the final disposition of the case (Jaffe et al., 1986).

Implications for Education

Abuse during pregnancy is not a topic that many people feel comfortable addressing. However, ignoring it will not make it go away. Helping professionals must recognize the magnitude of the problem and realize that an estimated six to seven per cent of pregnant women are being abused (Parish et al., 1996). The women's experiences clearly indicate the need for a raised level of awareness by helping professionals and society as a whole. It has been shown that helping professionals who receive information on domestic violence are more likely to assess women for abuse (Helton et al., 1987b). The following discussion provides recommended measures to be implemented by communities in the battle against domestic violence.

Education of Women and the General Public

It is in hindsight that the women were able to clearly identify their partners' behavior as abusive. The womens' ability to recognize their experiences as abuse were clouded by feelings of self doubt, self blame, confusion, and denial. Deb did not realize that her husband's criticisms, insults, threats, and control of her activities and access to finances were considered abusive behavior. She thought he had to hit her before she should seek help. Information on the types of abuse, dynamics of abusive relationships, and characteristics of abusers must be widely disseminated to the public through a variety of mediums. Multi-media forms such as newspaper articles, posters, and radio and television excerpts can be used to reach the general public. Information pamphlets and small tear off information sheets listings resources should be widely available in waiting rooms, examination rooms, and washrooms.

Prevention

Prevention should be a goal, as once the woman enters into the relationship, leaving is difficult. Prevention requires education on the characteristics of healthy relationships. The warning signs of abusive relationships should be incorporated into junior high school curriculum. It is evident both from findings from this study and the work of Bohn (1990) that abuse prior to pregnancy is likely to continue during pregnancy. Teenagers require knowledge of abuse to assist them in making healthy life decisions about acceptable behaviors if abuse is to be prevented in their relationships. In addition, the seven women talked about their low levels of self esteem. Curriculum content directed toward increasing the self esteem of females is foundational to decreasing the number of victims of abuse. The women believed the source of their partners' controlling behavior was insecurity. The development of self esteem in all children, regardless of gender, must not be over looked, with the goal of decreasing the number of victims and perpetrators in the future.

The message must be sent that society no longer tolerates abuse of women. Prevention begins with the socialization of children. Traditional roles of men and women and the sexist beliefs about the subservience of women that serve to promote and perpetuate the abuse of women must be challenged. Court mandated treatment of perpetrators which focuses on accepting responsibility for their behavior, learning alternate ways of dealing with anger and conflict, and increasing their self esteem are recommended (Bain et al., 1991).

Awareness and Attitude

The findings of this study and a study conducted by Limandri and Tilden (1996) clearly indicate the need for educational sessions for health professionals. Myths, personal judgments, and stereotypes continue to impede acknowledgment of the realities of battering during pregnancy. Content alone is not sufficient in sensitizing helping professionals to the complex issues surrounding abuse during pregnancy and the need to intervene. Time is needed for sharing of feelings and attitudes toward battering. Our own experiences shape our thoughts, feelings, and attitudes. Abuse occurs in all spectrums of society, therefore workshops for the helping professionals must be conducted in a sensitive manner, as the participants may be perpetrators or victims of abuse. A panel of guest speakers, including women who have been abused during pregnancy and experts who work with these victims, is an effective way to increase sensitivity to this issue. Inclusion of a law enforcement officer can enhance this essential community link. Case study methods can be useful in facilitating discussions on ethical reasoning. Clinical placements at women's shelters are recommended for nurses and physicians in basic education programs (McFarlane, 1989).

Role of Professionals

From the participants' reports, it is evident institutional policies which clearly identify the health care professional's role in assessing, reporting, documenting, and intervening would serve to increase their confidence when confronted with cases of suspected abuse. Implementing a 24 hour family violence information line accessible to helping professionals and the public would assist the victim with selecting the appropriate resource.

Helping professionals may feel discouraged when working with victims of abuse as it is common for the women to deny the problem or decline help.

These feelings are grounded in the desire to fix the woman's problem. Acceptance of and respect for the woman's decision is essential, even if it is contrary to a decision the helping professional would make. The woman should not be coerced on the basis of "what is best for her". It is important for professionals to understand the woman may not feel psychologically ready to make changes in her life. The role of the professional is to respect the woman's decision and support her throughout the process, in whatever phase she has currently reached (Turnbull Buehler, 1994). However, it is still helpful for women to know that when they are ready, there is support and guidance available for them (Bain et al., 1991). Contact between an abused woman and a helping professional can be viewed as a form of success. Maintaining contact and providing continued support is the essence of therapeutic nursing (McFarlane, 1989). Abused women possess many strengths. The goal of intervention needs to reflect an attitude of empowering women versus patronizing them. Interactions with others may influence the woman's decision, but ultimately the timing is decided by the woman as it becomes appropriate for her unique situation.

Suggestions for Further Study

Domestic violence during pregnancy is a phenomenon that is just beginning to be studied critically. The findings of this exploratory descriptive study contribute to the small amount of existing knowledge on abuse during pregnancy and give rise to questions for further qualitative and quantitative research.

Data saturation was reached for this relatively homogenous volunteer sample. Repetition of this study using a larger sample size would include those still in an abusive relationship. Further study needs to focus on diversity in cultural, educational, socio-economic, age range, and family backgrounds. Such a study would contribute valuable information to the present body of knowledge.

All of the women who participated in this study had left their abusive relationships and shared their perceptions of their experiences retrospectively. All participants had reached a point in healing when they felt safe to disclose their experiences. Further research on women who are currently in a relationship could provide additional insight into women's perceptions while living in an abusive environment.

All informants had accessed resources for abused women. Studies which would allow comparison of the perspectives of women who have, with those who have not, sought counseling would provide insight into how counseling influences their perspective. This information would assist us to understand the degree of effectiveness of current resources and the barriers encountered by women to accessing resources.

Only one informant was pregnant at the time of the interview. Research conducted with women who were currently pregnant could provide additional insight into the issues of abuse during pregnancy.

Research studies are currently being conducted which indicate high prevalence rates of abuse (21.7%) within adolescent relationships (Parker, McFarlane, Soeken, Torres, & Campbell, 1993). Bullock and McFarlane (1988; 1990) assessed 200 pregnant adolescents to establish prevalence of battering during teen pregnancy. Twenty-six percent of the teens reported being in a physically abusive relationship, with 40-60% stating the battering had either begun or escalated with pregnancy. Interestingly, 65% had not talked to anyone about the abuse and no one had reported the abuse to law enforcement agencies. Further studies in this area are indicated, the results of which may provide information on the issues faced by adolescents and give direction to specific intervention strategies with this population of victims.

All of the women talked about their low levels of self esteem. Continued study of the formation, development, and maintenance of self esteem in females is indicated as it is a prevalent characteristic of abuse victims. Studies to examine the profiles of perpetrators are also indicated.

Further research to investigate factors that deter helping professionals from detecting and intervening in situations of domestic violence is indicated. Until this phenomenon is understood changes in practice will be impeded.

One informant terminated her pregnancy, all of the informants either considered having a therapeutic abortion or wished the pregnancy would be spontaneously aborted. These findings are similar to those reported by Evins and Chescheir (1996). As both studies had relatively small populations, further research on the relationship between domestic violence, unwanted pregnancy, and termination of pregnancy is indicated.

The women reported a variety of health problems. Clearly abuse during pregnancy has detrimental effects on the well being of the woman and the child. Additional prospective studies are needed to relate time of abuse and entry into prenatal care (McFarlane et al., 1996). Early detection of abuse leads to better health outcomes for the woman and child. Although the women had sought helping professionals, the abuse they experienced went largely undetected. Evins & Chescheir (1996) have suggested the need for research on abuse screening with emphasis on the acceptability and efficacy of the timing of the administration of screening tools.

Wanting to Help Other Abused Women

Since leaving their relationships the women have reached a point in their lives where they were able to and had a desire to help other abused women. Helping other women was the major impetus for the women to participate in the study:

> I think I feel a little bit of relief that maybe I am possibly helping. I mean, even if me being in the study helps one person, it's worth it. If one person can hear and read what I've said and how I've felt and maybe make a change in their life or get out of an abusive relationship or have their partner at least forced to get into anger management or you know, some kind of drug and alcohol rehab or anything. Anything that's going to affect their relationship or their marriage positively, it's worth it. You know, one person. One kid even that's going to feel the effect of this, it's worth it (Amy, 760-768 B).

In addition to helping others, several of the women stated they felt that participating in the study was a beneficial process for them. For Deb, participating in the study gave her the sense that something positive will result from the experiences she endured:

> I'm glad somebody cares, and I'm glad to talk about it because then it looks like I didn't go through it in vain. It wasn't all for nothing. I always try to find some reason why God put me through this, you know. Of course, I have my beautiful daughter, that's one reason. But it shouldn't be the only reason (1541-1546 A).

For Amy, participating in the study helped her to gain a greater understanding of herself and abuse. She believes this awareness will assist her to make positive, healthy relationship choices in the future:

> I'm in the process of healing and you know, I go to a support group and I've learned through there that it's not like hashing it over again, all the time. But the more you talk about it and analyze it, the more you understand and I think that's very important. . . . The more I talk about it, the more I have to deal with it, the more I learn to understand it and the less likely I am to get back into another of those relationships. So I think it's really important that . . . women who are abused talk about it (680-702 B).

Summary

Abuse is a crime. To ignore abuse is to perpetuate abuse. As societal members and helping professionals it is essential that we regard abuse as our problem. Abuse during pregnancy is a serious threat to maternal and fetal well being and must be afforded the same attention as other antepartal risk factors. Violence may be a more common problem for pregnant women than pre-eclampsia, gestational diabetes, and placenta previa (Cunningham, MacDonald, Gant, Leveno, & Gilstrap, 1993).

A vigilant, multifaceted community response to abuse during pregnancy is required. The control and eventual elimination of abuse will require significant changes by all of us in our attitudes toward violence and in our traditional views of male and female roles. Understanding the silence is the first step in breaking the silence. Understanding the silence is three fold and requires understanding the reasons women remain silent, ways in which the perpetrators enforce the silence, and means by which helping professionals and society perpetuate the silence. Abuse is a private, sensitive topic and women must be supported, not judged by helping professionals. Implications for the entire family and society at large must be realized. The men who are most violent are more likely to abuse their partners during pregnancy with the abusive episodes being more severe and frequent (Bowker, 1983; Fagan et al., 1983). Women do not have to live with abuse. Helping professionals must be available and willing to assist them when they are ready to make changes in their lives. Assessment of and intervention for women experiencing abuse must become a routine part of prenatal care. Knowing how to detect domestic violence and when and how to intervene can change, or save, women's lives. Indeed, it may be the only opportunity we get.

REFERENCES

Aamodt, A. (1982). Examining ethnography for nurse researchers. Western Journal of Nursing Research, 4, 209-221.

Amaro, H., Fried, L. E., Cobral, H., & Zuckerman, B. (1990). Violence during pregnancy and substance use. American Journal of Public Health, 80(5), 575-579.

Bain, J., Bearinger, O., Currie, D., Finkel, K., Hargot, L., Lent, B., Miller, D., Pressman, B., Rolfe, T., & Wybrow, B. (1991). Reports on wife assault. Ontario Medical Association.

Baker, D. P. (1982). Trauma in the pregnant patient. Surgical Clinics of North America, 62(2), 275-289.

Berenson, A. B., San Miguel, V. W., & Wilkinson, G. S. (1992). Prevalence of physical and sexual assault in pregnant adolescents. Journal of Adolescent Health, 13, 466-469.

Berenson A. B., Stiglich, N. J., Wilkinson, G. S., & Anderson, G. D. (1991). Drug abuse and other risk factors for physical abuse in pregnancy among white non-Hispanic, black, and Hispanic Women. American Journal of Obstetrics and Gynecology, 164, 1491-1499.

Bohn, D. K. (1990). Domestic violence and pregnancy: Implications for practice. Journal of Nurse-Midwifery, 35(2), 86-98.

Bohn, D. K., & Parker, B. (1993). Domestic violence and pregnancy: Health effects and implications for nursing practice. In J. Campbell and J. Humphreys Nursing care of survivors of family violence (pp. 156-170). St. Louis: Mosby.

Bowker, L. H. (1983). Beating wife beating. Lexington, MA: Lexington Books.

Bradburn, N. M., & Sudman, S. (1981). Improving interview method and questionnaire design. San Fransisco, CA: Jossey-Bass Inc.

Bremer, C., & Cassata, L. (1986). Trauma in pregnancy. Nursing Clinics of North America, 21, 705-716.

Brendtro, M., & Bowker, L. H. (1989). Battered women: How can nurses help? Issues in Mental Health Nursing, 10, 169-180.

Brinkerhoff, M. B., & Lupri, E. (1988). Interspousal violence. Canadian Journal of Sociology, 13, 407-434.

Browne, A. (1989). When battered women kill. New York: Macmillan.

Buel, S. M., Candib, L. M., Dauphine, J., Sassetti, M. R., & Sugg, N.K. (1993). Domestic violence: It can happen to anyone. Patient Care, 27(18), 63-66.

Bullock, L., & McFarlane, J. (1988). A program to prevent battering of pregnant students. Response, 11, 18-19.

Bullock, L. F., & McFarlane, J. (1989). The birth weight/battering connection. American Journal of Nursing, 89(9), 1153-1155.

Campbell, J.C. (1986). Nursing assessment for risk of homicide with battered women. Advances in Nursing Science, 8(4), 36-45.

Campbell, J. C. (1989). A test of two explanatory models of women's responses to battering. Nursing Research, 38(1), 18-24.

Campbell, J. C., & Alford, P. (1989). The dark consequences of marital rape. American Journal of Nursing, 89(7), 946-949.

Campbell, J. C., & Humphreys, J. (1984). Nursing care of victims of family violence. Norwalk, CT: Appleton.

Campbell, J., & Humphreys, J. (1993). Nursing care of survivors of family violence. St. Louis: Mosby.

Campbell, J. C., Pliska, M. J., Taylor, W., & Sheridan, D. (1994). Battered women's experiences in the emergency department. Journal of Emergency Nursing, 20, 280-288.

Campbell, J. C., Poland, M. L., Waller, J. B., & Ager, J. (1992). Correlates of battering during pregnancy. Research in Nursing and Health, 15(3), 219-226.

Child Welfare Act, Revised Statutes of Alberta 1980, chapter c-8.1.

Christian, A. (1995). Home care of the battered pregnant woman: One battered woman's pregnancy. JOGN, 24(9), 836-842.

Cobb, A. R., & Hagermaster, J. W. (1987). Ten criteria for evaluating qualitative research proposals. Journal of Nursing Education, 26(4), 138-143.

Council on Scientific Affairs, American Medical Association. (1992). Violence against women: Relevance for medical practitioners. JAMA, 267(23), 3184-3189.

Cunningham, F. G., MacDonald, P. D., Gant, N. F., Leveno, K. J., & Gilstrap, L. C. (1993). Williams Obstetrics. (19th ed.). East Norwalk, CT: Appleton & Lange.

Dobash, R. E., & Dobash, R. P. (1979). Violence against wives. New York: Free Press.

Downey, J., & Howell, J. (1976). Wife battering: A review and preliminary inquiry into local incidence, needs, and resources. United Way of Greater Vancouver.

Evins, G., & Chescheir, N. (1996). Prevalence of domestic violence among women seeking abortion services. Women's Health Issues, 6(4), 204-210.

Fagen, J., Stewart, D., & Hanson, K. (1983). Violent men or violent husbands? In D. Finklehor, R. Gelles, G. Hotaling, & M. Straus (Eds.). The dark side of families (pp. 49-67). Beverly Hills: Sage.

Field, P. A., & Morse, J. A. (1985). Nursing Research: The application of qualitative approaches. Rockville, M. D: Aspen.

Flynn, J. (1977). Recent findings related to wife abuse. Social Case Work, 58(1), 13-20.

Gayford, J. J. (1978). Battered wives. In J. P. Martin (Ed.). Violence and the family (pp.19-39). New York: John Wiley & Sons.

Gazmariarian, J. A., Adams, M. M., Saltzman, L. E., Johnson, C. H., Bruce, F. C., Marks, J. S., & Zahniser, S. C. (1995). The relationship between pregnancy intendedness and physical violence in mothers of newborns. Obstetrics and Gynecology, 85, 1031-1038.

Gazmariarian, J. A., Lazorick, S., Spitz, A. M., Ballard, T. J., Saltzman, L. E., & Marks, J. S. (1996). Prevalence of violence against pregnant women. JAMA, 275(24), 1915-1920.

Gelles, R. J. (1988). Violence and pregnancy: Are pregnant women at greater risk of abuse? Journal of Marriage and the Family, 50, 841-847.

Goodwin, T. M., & Breen, M. T. (1990). Pregnancy outcome and fetomaternal hemorrhage after noncatastrophic trauma. American Journal of Obstetrics and Gynecology, 162(3), 665-671.

Hart, B. (1988). Beyond the "duty to warn": A therapist's "duty to protect" battered women and children. In K. Yllo and M. Bogard (Eds.), Feminist perspectives on wife abuse (pp. 234-248). Newbury Park: Sage.

Hatcher, R. A., Guest, F., Stewart, F., Stewart, G. K., Trussel, J., Cerel, S., & Cates, W. (1986). Contraceptive Technology 1986-1987. New York: Irvington.

Helton, A. S. (1985). The pregnant battered woman. Response, 9(1), 22-23.

Helton, A. S. (1986). Battering during pregnancy. American Journal of Nursing, 86(8), 910-913.

Helton, A. S. (1987). Protocol of care for the battered woman. Houston: March of Dimes Birth Defects Foundation.

Helton, A. S., McFarlane, J., & Anderson, E. (1987a). Battered and pregnant: A prevalence study. American Journal of Public Health, 77(10), 1337-1339.

Helton, A. S., McFarlane, J., & Anderson, E. (1987b). Prevention of battering during pregnancy: Focus on behavioral change. Public Health Nursing, 4(3), 166-174.

Helton, A. S., & Snodgrass, F. G. (1987). Battering during pregnancy. BIRTH Issues in Perinatal Care and Education, 14(3), 142-147.

Hilberman, E., & Munson, K. (1978). Sixty battered women. Victimology, 2, 460-470.

Hillard, R. J. A. (1985). Physical abuse in pregnancy. Obstetrics and Gynecology, 66, 185-190.

Innes, J. E., Ratner, P. A., Finlayson, P. F., Bray, D., & Giovannetti, P. B. (1991). Models and strategies of delivering community health services related to woman abuse. (unpublished report of National Health Research and Development Program funded project) University of Alberta, Edmonton, Alberta.

Jaffe, P., Wolfe, D., Telford, A., & Austin, G. (1986). The impact of police charges in incidents of wife abuse. Journal of Family Violence, 1, 37-49.

Jezierski, M. (1994). Abuse of women by male partners: Basic knowledge for emergency nurses. Journal of Emergency Nursing, 20(5), 361.

Kennedy, L. W., & Dutton, D. G. (1987). The incidence of wife assault in Alberta (Edmonton Area Series Rep. No. 53). Edmonton: University of Alberta, Population Research Laboratory and Department of Sociology.

Kennedy, L. W., & Dutton, D. G. (1989). The incidence of wife assault in Alberta. Canadian Journal of Behavioral Science, 21(1), 40-54.

Leininger, M. M. (1969). Ethnoscience: A promising research approach to improve nursing practice. Image, 3, 2-8.

Leininger, M. M. (1984). Qualitative research methods for nursing. New York: Grune & Stratton.

Lent, B. (1991). Reports on wife assault. Ottawa: Ontario Medical Association.

Limandri, B. J., & Tilden, V. P. (1996). Nurses' reasoning in the assessment of family violence. Image: Journal of Nursing Scholarship, 28(3), 247-252.

MacNeil, N. (1993). Becoming a father to a stillborn child. Unpublished master's thesis, University of Alberta, Edmonton.

Martin, D. (1976). Battered wives. San Francisco, CA: Glide.

McFarlane, J. (1989). Battering during pregnancy: Tip of an Iceberg Revealed. Women and Health, 15(3), 69-84.

McFarlane, J. (1992). Battering in pregnancy. In C. M. Sampselle (Eds.), Violence against women: Nursing research, education, and practice issues (pp. 205-218). New York: Hemisphere Publishing Corporation.

McFarlane, J., Christoffel, K., Bateman, L., Miller, V., & Bullock, L. (1991). Assessing for abuse: Self-reports versus nurse interview. Public Health Nursing, 8(4), 245-250.

McFarlane, J., & Parker, B. (1996). Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. JOGNN, 25(4), 313-320.

McFarlane, J., Parker, B., & Soeken, K. (1996). Abuse during pregnancy: Associations with maternal health and infant birth weight. Nursing Research, 45(1), 37-42.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. Journal of the American Medical Association, 267(3), 3176-3178.

McLeer, S. V., & Anwar, R. (1989). A study of battered women presenting in an emergency department. American Journal of Public Health, 79(1), 65-66.

Meskin, L. H. (1994). If not us, then who? Journal of the American Dental Association, 125(10), 12.

Morgan, S. J. (1987). Parental grief following the loss of an infant in NICU. Unpublished master's thesis, University of Alberta, Edmonton.

Morse, J. M. (Ed.). (1992). Qualitative health research. Newbury Park, CA: Sage.

Moss, V. A., & Taylor, W. K. (1991). Domestic violence. AORN Journal, 53(5), 1158.

O'Shea, L. (1996). Domestic violence in pregnancy. Modern Midwife, 6(3),10-12.

Parish, B., Boroditsky, R. S., Grant, L. J., Lefebvre, Y., Rourke, M. E., Steben, M., Thomson, S., Woodrow, P., & Lamont, J. (1996). Policy statement: Violence against women. SOGN, 18(8), 803-807.

Parker, B. (1991, May). Intentional injury during pregnancy. Paper presented at the Fourth National Nursing Conference on Violence Against Women, Detroit, MI.

Parker, B. (1993). Abuse of adolescents: What we can learn from pregnant teen-agers? Perinatal and Women's Health Nursing, 4(3), 363-370.

Parker, V. F. (1995). Battered. RN, 58(1), 26-29, 33.

Parker, B., McFarlane, J., Soeken, K., & Bullock, L. (1994). Abuse during pregnancy: Effects on maternal complications and birth weight in adult and teenage women. Obstetrics and Gynecology, 84, 323-328.

Parker, B., McFarlane, J., Soeken, K., Torres, S., & Campbell, D. (1993). Physical and emotional abuse in pregnancy: A comparison of adult women and teen women. Nursing Research, 42, 173-177.

Ratner, P. A. (1991). The health problems and health care utilization patterns of wives who are physically and/or psychologically abused. Unpublished master's thesis, University of Alberta, Edmonton.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Saunders, D. G. (1986). When battered women use violence: Husband-abuse or self defense? Violence and Victims, 1, 47-60.

Shipley, S., & Sylvester, D. (1982). Professional attitudes toward violence in close relationships. Journal of Emergency Nursing, 8(2), 88-91.

Spradley, J. (1979). The ethnographic interview. New York: Holt, Rinehart, & Winston.

Stacey, W., & Shupe, A. (1983). The family secret: Domestic violence in America. Boston: Beacon Press.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a "private" event. International Journal of Health Services, 9(3), 461-493.

Stark, E., Flitcraft, A., Zuckerman, D., Grey, A., Robison, J., & Frazier, W. (1981). Wife abuse in the medical setting. Domestic Violence Monograph Series, 7, 7-41.

Stewart, E. P., & Campbell, J. C. (1989). Assessment of patterns of dangerousness with battered women. Issues in Mental Health Nursing, 10, 245-260.

Stewart, D. E., & Cecutti, A. (1993). Physical abuse in pregnancy. Canadian Medical Association Journal, 149, 1257-1269.

Straus, M. A. (1979). Measuring intra-family conflict and violence: Conflict tactics (CT) scales. Journal of Marriage and the Family, 41, 75-88.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Strauss, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). Behind closed doors: Violence in the American family. New York, NY: Doubleday/Anchor.

The violence against women survey. (1993). The Daily. Ottawa: Statistics Canada.

Turnbull Buehler, E. J. (1994). The process of leaving an abusive relationship. Unpublished master's thesis, University of Alberta, Edmonton.

Ulrich, Y. C. (1991). Women's responses for leaving abusive spouses. Health Care for Women International, 12, 465-473.

Walker, L. E. (1979). The battered woman. New York: Harper & Row.

Walker, L. (1984). The battered woman syndrome. New York: Harper & Row.

Walker, B., Jones, J. S., & Krohmer, J. (1991). To report or not to report: Emergency services' response to elder abuse. Prehospital Disaster Medicine, 6, 380.

Webster, J., Sweett, S., & Stolz, T. A. (1994). Domestic violence in pregnancy: A prevalence study. Medical Journal of Australia, 161, 466-470.

Whitley, N. (1985). A manual of clinical obstetrics. Philadephia: J. B. Lippincott.

Williams, L. S. (1995). Failure to pursue indications of spousal abuse could lead to tragedy, physicians warned. Canadian Medical Associaton Journal, 152, 1488-1491.

Yakimishyn, S. (1991). "Trust is the key" to the secret of family violence: A manual for nurses and other health care professionals. Edmonton, Alberta: Victorian Order of Nurses.

BIBLIOGRAPHY

Agar, M. H. (1980). The professional stranger: An informal introduction to ethnography. New York: Academic Press.

Anderson, C. (1996). Looking out for the abused pregnant woman. American Journal of Nursing, 96(7), 54.

Basso, M.C. (1995). Pregnant women in abusive relationships. Canadian Nurse, 91(4), 21.

Brink, P., & Wood, M. (Eds.). (1989). Advanced design in nursing research. Newbury Park, CA: Sage.

Campbell, J.C. (1992). A review of nursing research on battering. In C.M. Sampselle (Eds.), Violence against women: Nursing research, education, and practice issues (pp. 69-81). New York, NY: Hemisphere Publishing Corp.

Dobash, R. E., & Dobash, R. P. (1979). Violence against wives: A case against the patriarchy. New York: Free Press.

Ford, J. S., & Reutter, L. I. (1990). Ethical dilemmas associated with small samples. Journal of Advanced Nursing, 15(2), 187-191.

Hammersley, M., & Atkinson, P. (1983). Ethnography: Principles in practice. New York: Tavistock.

Homicide in Canada: A statistic synopsis, Justice Statistics Division, Statistics Canada, Ottawa (1989).

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. American Journal of Occupational Therapy, 45(3), 214-222.

Landenburger, K. (1989). A process of entrapment in and recovery from an abusive relationship. Issues in Mental Health Nursing, 10, 209-227.

Limandri, B. J. (1987). The therapeutic relationship with abused women. Journal of Psychosocial Nursing, 25(2), 9-16.

Malestic, S. (1995). Fight violence with forensic evidence. RN, 58(1), 30-33.

Martin, S. L., English, K. T., Anderson Clark, K., Cilenti, D., & Kupper, L. L. (1996). Violence and substance use among North Carolina pregnant women. American Journal of Public Health, 86(7), 991-998.

McEndree, B. (1996). The prevalence of smoking among women who report a history of physical and sexual abuse. Short Communications, 21(3), 148-150.

McFarlane, J., Parker, B., & Soeken, K. (1994). Abuse during pregnancy: Frequency, severity, perpetrator, and risk factors of homicide. Public Health Nursing, 12(5), 284-289.

Norton, L. B., Peipert, J., Zierler, S., Lima, B., & Hume, L. (1995). Battering in pregnancy: An assessment of two screening methods. Obstetrics and Gynecology, 85(3), 321-325.

O'Campo, P., Gielen, A. C., Faden, R. R., Xue, X., Kass, N., & Wang, M. (1995). Violence by male partners against women during the childbearing year: A contextual analysis. American Journal of Public Health, 85(8), 1092-1097.

Parker, B., & Ulrich, Y. (1990). A protocol of safety: Research on abuse of women. Nursing Research, 39, 248-250.

Pearsall, M. (1965). Participant observation as a role and a method in behavioral research. Nursing Research, 14(1), 37-42.

Rodgers, B. L., & Cowles, K. V. (1993). The qualitative research audit trail: A complex collection of documentation. Research in Nursing and Health, 16(3), 219-226.

Sammons, L. N. (1981). Battered and pregnant. American Journal of Maternal Child Nursing, 6, 246-250.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. Image: Journal of Nursing Scholarship, 23(3), 161-166.

Torres Shimmons, C. (1992). Battering during pregnancy: An exploratory study. Dissertation Abstracts International, 53(6), Order Number DA9223761.

Wilson, L. M., Reid, A. J., Midmer, D. K., Biringer, A., Carroll, J.C., & Stewart, D. E. (1996). Antenatal psychosocial risk factors associated with adverse postpartum family outcomes. Canadian Medical Association Journal, 154(6), 785-799.

Wilt, S., & Olson, S. (1996). Prevalence of domestic violence in the United States. Journal of the American Medical Womens Association, 51(3), 77-82.

Wyatt, G. S., & Peters, S. D. (1986). Methodologic considerations in research on the prevalence of child sexual abuse. Child Abuse and Neglect, 10, 241-251.

APPENDIX A

ADVERTISEMENT FOR INFORMANTS

Women Who Have Been Abused During Pregnancy

I am a student in a master of nursing program. I am studying the experiences of women who have been physically or emotionally mistreated by their partner while they were pregnant. Examples of mistreatment may include being hit, kicked, or threatened. If you are currently pregnant and are being hurt, or were hurt during a pregnancy within the past five years, and would be willing to talk about your experience, I would like to talk with you about my study. Please call 4-- ---- for more information. If you are leaving a message on the answering machine at the same number, please leave your name, phone number, and a safe time for me to return your call. The message that you leave will be kept confidential. I will be the only person who hears your message.

WINGS and WIN House Advertisements

On the advice of Executive Directors Cynthia MacNichol and Patricia Garrett the following sentence will be added on the advertisement posted at the Women's Shelters:

The organizations of WINGS and WIN House have agreed to post this advertisement. This study has met the agencies' requirements for ethical consideration and confidentiality of participants.

APPENDIX B

CRITERIA FOR SELECTION OF INFORMANTS

- English speaking woman
- 18 years of age or older
- willing to participate
- expresses an interest in participating in the study, as opposed to expressing a need for therapeutic assistance, in which case a referral to appropriate resources would be made.
- defines self as having been abused during a current pregnancy or abused during a pregnancy within the past 5 years, by her intimate partner.
- able to express her thoughts, feelings, and perceptions.

If asked for clarification of "abuse"
"abuse" = damage, pain, harm, hurt, violence, force, coercion, threaten

APPENDIX C

INFORMATION FOR POTENTIAL RESEARCH PARTICIPANTS

My name is Heather Weidenhamer. I am a student in a master of nursing program. I am studying the experiences of women who have been abused during their pregnancy. Nurses need to know more about the events and feelings that women have when they are physically or emotionally abused during their pregnancy. I hope this study will help nurses to give better care to women who are battered when they are pregnant. If you have been battered when you were pregnant you may want to join this study.

Battering occurs when a woman is physically, emotionally, or sexually mistreated by an intimate partner. This mistreatment may threaten or endanger her security or her survival. If you join this study:

- you would need to meet with me, or talk to me by telephone. This will be for one to three times, for about one hour each time.
- these talks could take several hours of your time.
- we will arrange to meet, or talk on the phone, at a time and place that is convenient for you.
- you decide how long you want to talk to me and how much you want to tell me.
- our talks will be tape-recorded and then typed.
- any names mentioned will not be typed.
- only I will know your real name.
- your name will not be used in any report of the study.
- I will write the report of the study so that others will not know that you took part in the study.
- I will keep all of the tapes and reports of your interview in a locked cupboard to protect your privacy.
- typed copies of the interviews (with names removed) may be used for future research if ethical approval is received.
- if you say something, and then you wish you had not said it, please tell me. I can erase that part of the tape if you want me to.

If you disclose information during an interview that indicates that a child has been physically, emotionally, or sexually abused or neglected this will be reported to the Child Welfare Department. I will discuss this with you first.

If you want to learn more about this study, please call me at 4-- ----. Please leave a message on my answering machine. I will be glad to answer any of your questions. If you choose to join the study, we will arrange a meeting or telephone interview at your convenience. If you join this study, you may stop at any time without explaining your reasons.

APPENDIX D

INFORMED CONSENT FORM

Research Project Title:	An exploration of the experiences of women who have been battered during pregnancy
Researcher:	Heather Weidenhamer RN, BScN Master of Nursing Candidate Faculty of Nursing University of Alberta Phone: 4-- ----
Thesis Supervisor:	Dr. P. A.Field Professor Faculty of Nursing University of Alberta Phone: 492-6248

Purpose of the Study: The purpose in this study is to describe the experience of women who have been abused during pregnancy by their partner. This information will increase nurses' understanding of what it is like, and how nurses can help them.

Procedure: I will talk to you about your experience of being hurt during your pregnancy. There will be one to three interviews, each lasting about one to two hours. The interviews will be at a time and place convenient to you. The interview could be done by telephone, if you prefer. The interviews will be tape-recorded. I will mark our taped interview(s) with a code name. Only I will know the code name. The consent form will be destroyed after five years after the study is finished. A secretary will type your taped interview without names. The tapes and typed copy will be stored in a separate locked cupboard and kept for seven years after the study is finished. The typed copy may be used for another study in the future. If it is, I will get approval from an ethics committee, as I did for this research. Your real name will not be mentioned in any of the reports or talks about this study. Parts of our talks may be used in the report. I will write the report so others will not know that you were in the study. The information and findings of this study may be shared with other health care workers.

Participation: You do not have to be in this study unless you want to be. If you want to leave the study at any time, just let me know. You can also refuse to answer any questions. If you tell me something and then decide you would prefer not to have said it, please tell me. If you wish, I will erase this portion of the tape. If you mention any needs for health care, counselling, or other help, I will give you a phone number to call to get that help. If you wish you may contact the research supervisor, Peggy Anne Field, to discuss this study. The Child Welfare Act states that child abuse or neglect must be reported. Child abuse is the mistreatment or neglect of children. Child abuse may be physical, emotional, or sexual. It threatens the well-being or security of the child. If you tell me something about child abuse or neglect which is happening, or that a child is at risk I will talk to you about it. I will also need to provide this information to Child Welfare. Otherwise I will keep everything you tell me in confidence.

I will not contact you after the study is over, to protect your privacy. You may get a final report of the study by filling out the attached sheet, or by contacting the researcher.

Risks: Possible risks to you from being in this study have been explained. You may not gain anything from the research. I hope that the findings from this study will improve care of women who are battered during their pregnancy in the future. I want to understand what this experience is like for you. I will ask very personal questions. You may find there are things which are painful to talk about. Anytime you wish, you may stop the interview. You may also choose not to answer some questions. If you wish, I can give you names of people who can help you with your problems.

If you have concerns or questions at any time, please contact the researcher, Heather Weidenhamer, at 4-- ----.

Consent:

I, ______________________________ have read this consent form and discussed it with the researcher, Heather Weidenhamer. I agree to take part in this study called 'an exploration of the experience of women who have been battered during pregnancy'. I have asked any questions that I have about the study, and about my part in it. The researcher or the supervisor has answered all my questions. I know I can contact them if I have any questions about the study in the future.

I understand that typed material (without names) from this study may be used in future research. I agree to let this material be used, if approval is first received from an ethics committee.

I know that I may leave the study at any time without explaining my reasons.

I have been given a copy of this consent to keep.

____________________________________ ____________________

Signature of Participant Date

____________________________________ ____________________

Signature of Researcher Date

I know I may call in December 1995 to receive a report of the study,

or

I would like to receive a report of this study at the address below:

____

____

____

____

APPENDIX E

EXAMPLES OF GUIDING QUESTIONS FOR INFORMANT INTERVIEWS

(These are examples and will not necessarily all be asked if not applicable to particular informants or if answered spontaneously. Questions may not be used in order. Questions may not all be asked during the first interview.)

We have discovered that many women are hurt by their partners, either physically or emotionally, during pregnancy. I am interested in helping women who have been hurt by their partners. Can you tell me about your experience?

Probes:

1. Describe the abusive relationship you were involved in during your pregnancy.
2. Tell me about the first time the abuse occurred.
3. Has your life been affected by the abuse? (If informant responds affirmatively, she will be asked to describe how she feels her life was affected. If informant responds negatively, she will be asked to expand on why she does not feel her life was affected by the abuse.)
4. Has your health been affected by the abuse? (If informant responds affirmatively, she will be asked to describe how she feels her health was affected. If informant responds negatively, she will be asked to expand on why she does not feel her health was affected by the abuse.)
5. Has the health of your child been affected by the abuse? (If informant responds affirmatively, she will be asked to describe how she feels her child's health was affected. If informant responds negatively, she will be asked to expand on why she does not feel her child's health was affected.)
6. Did you tell anyone about your abusive situation? (If informant responds affirmatively, she will be asked to describe the experience of telling another person. If the informant responds negatively she will be asked to describe why she did not tell anyone about her abusive situation.)
7. How do you explain what happened to you in this abusive relationship?

Other guiding questions may include asking for an example to further clarify an experience that the informant has identified.

APPENDIX F

BIOGRAPHICAL DATA: INFORMANT

1. **What is your year of birth?** ______________

2. **In what country were your born?** ______________

3. **What is your present marital status?**
    - married ____________
    - stable partnership ____________
    - separated ____________
    - divorced ____________
    - widowed ____________
    - single ____________
    - other (specify) ____________

4. **How many children do you have?**
    - none ____________
    - actual number ____________

5. **How many times have you been pregnant?** ____________

6. **Are you presently working?**
    - full time ____________
    - part time ____________
    - going to school ____________
    - keeping house ____________
    - unemployed ____________
    - other (specify) ____________

7. **What is your approximate level of income?**
    - Individual ____________
    - Combined ____________

8. What is the highest level of education you have completed?
   No school ____________
   Elementary School ____________
   Junior High ____________
   High School ____________
   Post Secondary ____________
   University :
     Diploma ____________
     Bachelor Degree ____________
     Master Degree ____________
     Doctoral Degree ____________

9. How long have you been / or were you with, your abusive partner?
   ____

10. Did your partner abuse you before you were pregnant?
   ____

11. Have you had any health problems during this pregnancy?
   (specify) ____________

APPENDIX G

COMMUNITY RESOURCES FOR REFFERAL OF INFORMANTS

Edmonton Shelters

WIN House (Shelter for battered women; Edmonton)	476-0058
Lurana Family Centre	424-5875
A Safe Place (Shelter for battered women; Sherwood Park)	464-7233
Women's Emergency Shelter	423-5302
Y.W.C.A.	423-9922
McDougall House	426-1409

Second Stage Housing

Edmonton - WINGS	426-4985
Calgary - Discovery House	277-0718

Other Community Resources

The Family Center (programs for men and women)	423-2831
St. Albert Stop Abuse In Families (SAIF)	460-2195
Distress and Suicide Line	424-4252
Sexual Assault Center	423-4121
Police	423-4567
Alberta Alcohol & Drug Abuse Commission	427-2736
Victorian Order Of Nurses (People in Crisis Program)	466-0293
STD Clinic	427-2834
Alberta Mental Health Services	427-4444
The Worth Center (Women's Recovery)	424-0650
Changing Together (Center for Immigrant Women)	421-0175
Support Network	482-4357
Changing Ways (Men's Support Group)	439-4635
Native Counselling Services	423-2141
Community and Social Service Information	424-3242
University Walk-in Clinic	492-6501

Alberta Family and Social Services District Offices

Financial Assistance

Alberta Social Services District Offices

Edmonton West	482-9511
Edmonton North	473-8411
Edmonton Central	493-7511
Edmonton South	438-8111

Canada

Indian and Northern Affairs	495-2777

Child Welfare

Information/Intake/Investigation	453-7711
Emergency Social Services (Crisis Unit) after 4:30 p.m.	427-2822
	427-3390
Day Care Subsidy	427-0958
Children In Care	431-6611
Family Support	422-3237
Child Abuse Hot Line	0 (ask for Zenith 1234)

Legal Help

Legal Aid	427-7575
Family Court	427-2743
Student Legal Services	432-2226
Lawyer Referral Service	1-800-661-1095

City of Edmonton Community and Family Services

Millwoods	428-5890
Jasper Place	428-5908
Glengarry	428-2414
Mill Creek	428-2625
Beverly	428-5957
Castledowns	428-8605
Pleasantview	428-5441
Westmount	428-4967
Clareview	496-5860

Medical Referral

Refer to Edmonton Telephone Yellow Pages	pp. 1335-47

APPENDIX H

SECONDARY INFORMANT CONSENT FORM

Research Project Title:	An exploration of the experiences of women who have been battered during pregnancy
Researcher:	Heather Weidenhamer RN, BScN Master of Nursing Candidate Faculty of Nursing University of Alberta Phone: 4-- ----
Thesis Supervisor:	Dr. P. A. Field Professor Faculty of Nursing University of Alberta Phone: 492-6248

Purpose of the Study: The purpose in this study is to describe the experience of women who have been abused during pregnancy by their partner. This information will increase nurses' understanding of what it is like, and how nurses can help them.

Procedure: I will talk with you for the purpose of confirming information obtained from women who were hurt during pregnancy. We will talk for about one hour. The interviews will be at a time and place convenient to you. The interview could be done by telephone, if you prefer. The interviews may be tape-recorded. I will mark our interview with a code name. Only I will know the code name. The consent form will be destroyed five years after the study is finished. A secretary will type your taped interview without names. The tape and typed copy will be stored in a separate locked cupboard and kept for seven years after the study is finished. The typed copy may be used for another study in the future. If it is, I will get approval from an ethics committee, as I did for this research. Your real name will not be mentioned in any of the reports or talks about this study. Parts of our talks may be used in the report. I will write the report so others will not know that you were in the study. The information and findings of this study may be shared with other health care workers.

Participation: You do not have to be in this study unless you want to be. If you want to leave the study at any time, just let me know. You can also refuse to answer any questions. If you tell me something and then decide you would prefer not to have said it, please tell me. If you wish, I will erase this portion of the tape. If you mention any needs for health care, counselling, or other help, I will give you a phone number to call to get that help. If you wish you may contact the research supervisor, Peggy Anne Field, to discuss this study. The Child Welfare Act states that child abuse or neglect must be reported. Child abuse is the mistreatment or neglect of children. Child abuse may be physical, emotional, or sexual. It threatens the well-being or security of the child. If you tell me something about child abuse or neglect which is happening or that a child is at risk I will talk to you about it. I will also need to provide this information to Child Welfare. Otherwise I will keep everything you tell me in confidence.

I will not contact you after the study is over, to protect your privacy. You may get a final report of the study by filling out the attached sheet, or by contacting the researcher.

Risks: Possible risks to you from being in this study have been explained. You may not gain anything from the research. I hope that the findings from this study will improve care of women who are battered during their pregnancy in the future. I want to understand what this experience is like for you. I will ask very personal questions. You may find there are things which are painful to talk about. Anytime you wish, you may stop the interview. You may also choose not to answer some questions. If you wish, I can give you names of people who can help you with your problems.

If you have concerns or questions at any time, please contact the researcher, Heather Weidenhamer, at 4-- ----.

Consent:

I, ______________________________ have read this consent form and discussed it with the researcher, Heather Weidenhamer. I agree to take part in this study called 'an exploration of the experience of women who have been battered during pregnancy'. I have asked any questions that I have about the study, and about my part in it. The researcher or the supervisor has answered all my questions. I know I can contact them if I have any questions about the study in the future.

I understand that typed material (without names) from this study may be used in future research. I agree to let this material be used, if approval is first received from an ethics committee.

I know that I may leave the study at any time without explaining my reasons.

I have been given a copy of this consent to keep.

______________________________ ____________________

Signature of Participant Date

______________________________ ____________________

Signature of Researcher Date

I know I may call in December 1995 to receive a report of the study,

or

I would like to receive a report of this study at the address below:

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